

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12839

12861

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel 41</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Laurel Hospital</b>				d. STREET ADDRESS/ <b>Box. 212 A Gorman Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EDWARD First KIRBY Middle ALLEN Last</b>				4. DATE OF DEATH Month <b>November</b> Day <b>10</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4 Oct. 1959</b>		9. AGE (In years last birthday) yrs. <b>1</b> Months <b>7</b>	IF UNDER 1 YEAR Hours <b>7</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Daniel A. Allen</b>				14. MOTHER'S MAIDEN NAME <b>Joan A. Knowski</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Daniel A. Allen (Father) Same as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) stating the underlying cause last. DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John T. Maloney</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>November 10, 1959</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>11/12/59</b>		<b>Carver Memorial Park</b>		<b>Mount Airy Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>De Witt Canabdan, Laurel, Md</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Kline</b>	

2033254XV5

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS

NAME OF DECEASED

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DIAGNOSIS

AGE AT DEATH

SEX

RACE

RELIGION

MARRIAGE

EDUCATION

OCCUPATION

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12862

CERTIFICATE OF DEATH

Reg. Dist. No. 12840

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Berwyn Heights</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>8700 62 Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lillian</b> Middle <b>Attick</b> Last <b>Attick</b>				4. DATE OF DEATH Month <b>November</b> Day <b>12</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-2-89</b>		9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months <b>70</b> Days <b>70</b> Hours <b>70</b> Min. <b>70</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>George W Bursey</b>				14. MOTHER'S MAIDEN NAME <b>Mary K Cloud</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		INFORMANT <b>Charles M Attick</b> Address <b>College Park, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331x</b> DUE TO <b>Cerebral Calcifications</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>2 days</b> (c) <b>3 yr +</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>3 yr +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1958</b> , 19 <b>NOV</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11/12</b> , 19 <b>59</b> , and that death occurred at <b>6:30</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Dr. Etienne</b>		ADDRESS (Street, city or town, state) <b>4713 - Berwyn Rd College Park, Md.</b> DATE SIGNED					
PHYSICIAN'S NAME (Type) <b>Dr. Etienne</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 16, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville Md.</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Hines</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12841

Reg. Dist. No.

12923

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>her. Touring Office</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights</u> d. STREET ADDRESS <u>1760 Atwood Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>James Irving Bagent</u>		<b>4. DATE OF DEATH</b> Month <u>Nov</u> Day <u>20</u> Year <u>1959</u>		<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u>			
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Oct 19, 1956</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>9. AGE</b> (In years last birthday) <u>3</u> yrs. <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>			
<b>11. BIRTHPLACE</b> (State or foreign country) <u>District of Columbia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>		<b>13. FATHER'S NAME</b> <u>William Bruscoe Bagent</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Windsor</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>			
<b>17. INFORMANT</b> <u>Mrs. Mary Bagent, same as #2</u> Address		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> DUE TO <u>754.5</u> Conditions, if any, which gave rise to immediate cause (b) <u>Congenital heart disease</u> (c), stating the underlying cause last. DUE TO					
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>					
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> o. m. p. m.					
<b>20d. INJURY OCCURRED</b> White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>James I. Boyd</u> M.D.		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b> <u>Nov 20, 1959</u>			
<b>EXAMINER'S NAME (Type)</b> <u>JAMES I. BOYD</u>		<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>Nov 23 1959</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>CEDAR HILL CEMETERY</u>			
<b>22d. LOCATION</b> (City, town, or county) (State) <u>SUITLAND MD</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W.W. Chambers Co.</u> ADDRESS <u>517-11th St. SE Wash, D.C.</u>					
<b>24a. REC'D BY REGISTRAR</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Krasa</u>		<b>DATE</b> <u>NOV 24 '59</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of Birth: \_\_\_\_\_

5. Place of Birth: \_\_\_\_\_

6. Date of Death: \_\_\_\_\_

7. Time of Death: \_\_\_\_\_

8. Place of Death: \_\_\_\_\_

9. Cause of Death: \_\_\_\_\_

10. Manner of Death: \_\_\_\_\_

11. Signature of Medical Examiner: \_\_\_\_\_

12. Signature of Coroner: \_\_\_\_\_

13. Signature of Registrar: \_\_\_\_\_

14. Signature of Physician: \_\_\_\_\_

15. Signature of Nurse: \_\_\_\_\_

16. Signature of Undertaker: \_\_\_\_\_

17. Signature of Burial Society: \_\_\_\_\_

18. Signature of Cemetery: \_\_\_\_\_

19. Signature of Funeral Home: \_\_\_\_\_

20. Signature of Other: \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12863

## CERTIFICATE OF DEATH

12842

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>P. G.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 Riverdale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Letand Memorial</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Virgil</u> Middle <u>G.</u> Last <u>Baldwin</u>				4. DATE OF DEATH Month <u>11</u> Day <u>6</u> Year <u>59</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT 11, 1890</u>		9. AGE (In years last birthday) <u>68</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Heating</u>		11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>DRURY Baldwin</u>				14. MOTHER'S MAIDEN NAME <u>Sue MILLIGAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-07-1141</u>		17. INFORMANT <u>(son) Russell Y.</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY heart disease</u> (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 day</u> <u>5 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Aug. 1930</u> to <u>Nov 6, 1959</u> , that I last saw the deceased alive on <u>Nov 5, 1959</u> , and that death occurred at <u>1239</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edgar E. Quayle</u>				DATE SIGNED <u>1822 Biltmore St NW</u>			
PHYSICIAN'S NAME (Type) <u>Edgar E. Quayle</u>				<u>Washington D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-9-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft L. ncoln</u>		22d. LOCATION (City, town, or county) (State) <u>Vladensburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home - Washington D.C.</u>				ADDRESS <u>Washington D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 10 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>			

CERTIFICATE OF DEATH

1908

Name of Deceased		Age		Sex	
James Gordon		25		Male	
Residence		Date of Death		Cause of Death	
1234 Riverdale St.		Jan 15, 1908		Pneumonia	
Occupation		Place of Death		Time of Death	
Farmer		Home		10:30 AM	
Physician		Burial		Burial Place	
Dr. J. H. Smith		Cemetery		St. Paul's	
Signature of Physician		Signature of Registrar		Signature of Minister	
[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Issue		Official Seal	
Jan 16, 1908		Barnstable		[Seal]	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

## CERTIFICATE OF DEATH

Reg. Dist. No.

12864

12843

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tamiet</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>41 Tamiet</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>421 Pr George St</u>		d. STREET ADDRESS <u>421 Pr George St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Burns</u> Last <u>Beall</u>		4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 10, 1880</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles S. Burns</u>		14. MOTHER'S MARDEN NAME <u>Louise Haslop</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. E. Beall, 421 Prince St. Tamiet Md</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Breast</u> DUE TO (b) <u>  </u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>170x</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>59</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 15, 1949</u> to <u>November 3, 1959</u> , that I last saw the deceased alive on <u>November 2, 1959</u> , and that death occurred at <u>8 A.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert S. McCenay</u> M.D.		ADDRESS (Street, city or town, state) <u>402 Main St. Laurel Md</u>	
PHYSICIAN'S NAME (Type) <u>Robert S. McCenay</u>		DATE SIGNED <u>Laurel Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/5/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Haslop Family Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Will</u> ADDRESS <u>Connelton, Laurel, Md</u>		24a. REC'D BY REGISTRAR <u>  </u> DATE <u>NOV 9 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO.

Blank form with horizontal lines for text entry.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12924 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12844

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u>		c. LENGTH OF STAY IN 1b <u>20 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) * <u>Greenbelt</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bill Stanton Road</u>				d. STREET ADDRESS <u>Bill Stanton Road</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>J</u> Last <u>Beall</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-23-1879</u>		9. AGE (In years last birthday) <u>79</u> yrs.	10. IF UNDER 1 YEAR Months <u></u> Days <u></u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William J Beall</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Ann Beall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Viola E. Beall - same address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>arteriosclerotic heart disease</u> (c) <u></u> DUE TO (a) stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u></u> o. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John J. Maloney</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John J. Maloney M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Nov-17-1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 21, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Trinity Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Collington Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 23 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12853

## CERTIFICATE OF DEATH

Reg. Dist. No. 12845

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGE</u> V		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville Md</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Blue Branch Nursing Home</u>			d. STREET ADDRESS <u>4718 GLENOAK RD</u>		
3. NAME OF DECEASED (Type or print) <u>AUGUST H BECKER</u>			4. DATE OF DEATH <u>11-19-1959</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 26, 1867</u>	9. AGE (In years last birthday) <u>92</u> yrs	10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED TAILOR</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>TAILOR</u>		
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>August H. Becker</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>			16. SOCIAL SECURITY NO <input type="checkbox"/>		
17. INFORMANT <u>Julius T. Becker</u>			Address <u>Box 706 Anandalee Va</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY EDEMA</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY INSUFFICIENCY</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) _____		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I attended the deceased from <u>11-27</u> , 19 <u>57</u> , to <u>11-19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11-19</u> , 19 <u>59</u> , and that death occurred at <u>4:50</u> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>6480 N.H. AVE - TAKOMA PARK MD.</u> DATE SIGNED <u>11/19/59</u>					
ACTUAL SIGNATURE <u>R.C. Kirchner</u> M.D.			PHYSICIAN'S NAME (Type) <u>R.C. KIRCHNER</u>		
22a. BURIAL, CREMAT. ON, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-21-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u>	
22d. LOCATION (City, town, or county) <u>Washington</u>		(State) <u>DC</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deaf Funeral Home</u> ADDRESS <u>4812 Ga. Ave NW Wash DC</u>			24a. REC'D BY REGISTRAR DATE <u>NOV 24 '59</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shows, is detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

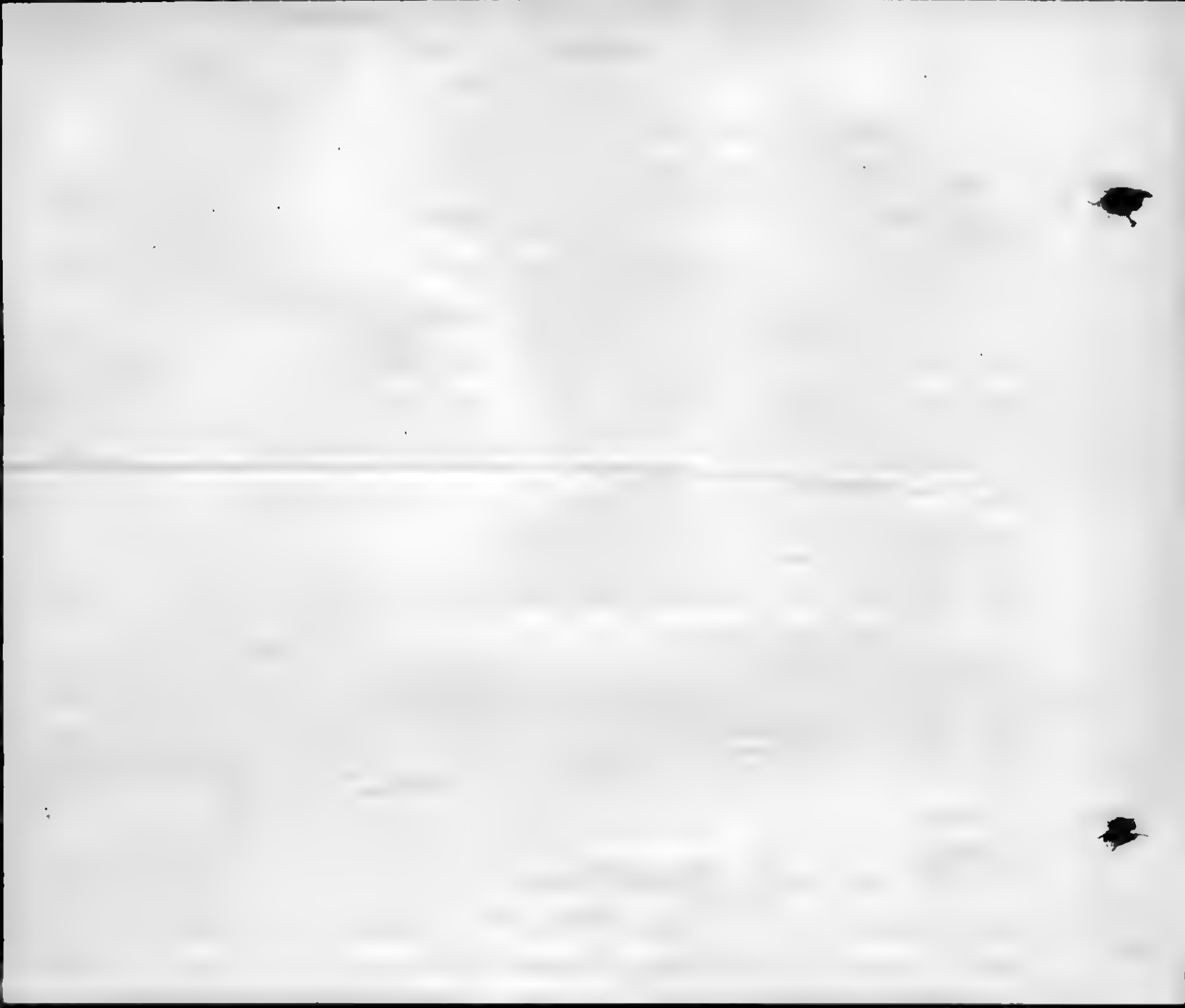
12865

## CERTIFICATE OF DEATH

12846

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <b>VIRGINIA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAUREL</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FARRS CHURCH</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>LAUREL SANITARIUM</b>		d. STREET ADDRESS <b>918 SPRING LANE</b>	
3. NAME OF DECEASED (Type or print) <b>GERTRUDE D. BEEK</b>		4. DATE OF DEATH Month <b>11</b> Day <b>26</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-23-1884</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>EMPLOYEE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE W. DEER</b>		14. MOTHER'S MAIDEN NAME <b>MARY L. YOUNG</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hospital Records LAUREL SANITARIUM</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY congestion (522)</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerotic heart disease (420)</b> DUE TO (c) <b>several yrs?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile Dementia (arteriosclerotic) tumor of calvaria gland (left)</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. d. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>9-22-1959</b> to <b>11-26-1959</b> , that I last saw the deceased alive on <b>11-26-1959</b> , and that death occurred at <b>4:50 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John P. Williams</b>		M.D. <b>LAUREL SANITARIUM</b> <b>11-26-59</b>	
PHYSICIAN'S NAME (Type) <b>ERIKA P. KRAEMER</b>		<b>LAUREL MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	22b. DATE THEREOF <b>11/26/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>COLUMBIA GARDENS</b>	22d. LOCATION (City, town, or county) (State) <b>ARLINGTON VA</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Carl Jenkins</b>		24a. REC'D BY REGISTRAR <b>DATE NOV 30 1959</b>	
ADDRESS <b>3524 Columbia Pike</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kram</b>	



12925

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMP SPRINGS</b>		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>DISTRICT OF COLUMBIA</b> b. COUNTY <b>WASHINGTON, D.C.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON, D.C.</b>		d. STREET ADDRESS <b>1104 MISSISSIPPI AVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSPITAL ANDREWS</b>		3. NAME OF DECEASED (Type or print) First Middle Last <b>Newbern Female BESOSA</b>		4. DATE OF DEATH Month Day Year <b>November 28 1959</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>CAU.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>28 Nov. 1959</b>	
9. AGE (In years last birthday) <b>Newborn</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		9. AGE (In years last birthday) <b>Newborn</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>	
13. FATHER'S NAME <b>JORGE BESOSA RAMIREZ</b>		14. MOTHER'S MAIDEN NAME <b>DOROTHY CARTER</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. ADDRESS <b>FROM CHART</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>773.5</b> DUE TO <b>Prematurity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Respiratory Failure</b> (c) <b>Interval between onset and death 1 hr 45 min</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>28 Nov 1959</b> to <b>28 Nov 1959</b> , that I last saw the deceased alive on <b>28 November 1959</b> , and that death occurred at <b>2 PM</b> , from the causes and on the date stated above.	
21. I certify that I attended the deceased from <b>28 Nov 1959</b> to <b>28 Nov 1959</b> , that I last saw the deceased alive on <b>28 November 1959</b> , and that death occurred at <b>2 PM</b> , from the causes and on the date stated above.		22. ADDRESS (Street, city or town, state) <b>USAF HOSPITAL ANDREWS</b>		23. DATE SIGNED <b>28 Nov 59</b>		ACTUAL SIGNATURE <b>George E Randall</b>		PHYSICIAN'S NAME (Type) <b>GEORGE E RANDALL, CAPT, USAF, MC</b>		24. LOCATION (City, town, or county) (State) <b>WASHINGTON D.C.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>George E Randall</b>	
26. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		27. DATE THEREOF <b>30 Nov 59</b>		28. NAME OF CEMETERY OR CREMATORY <b>DC MORGUE</b>		29. LOCATION (City, town, or county) (State) <b>WASHINGTON D.C.</b>		30. REC'D BY REGISTRAR DATE <b>DEC 1 '59</b>		31. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		32. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

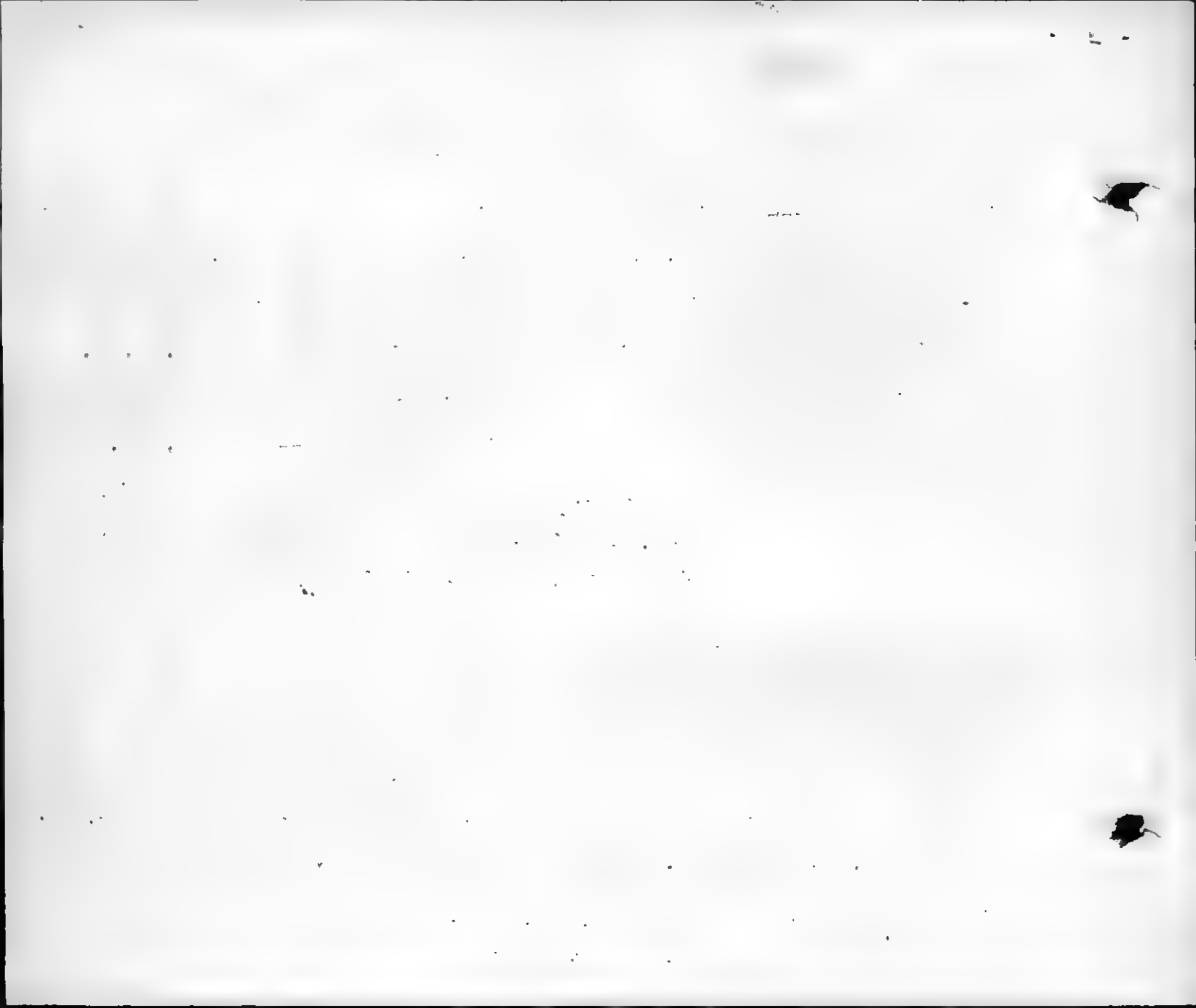
Reg. Dist. No.

12866

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>13 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>General Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Bertie</b> Middle <b>Delphia</b> Last <b>Bolithe</b>				4. DATE OF DEATH Month <b>Nov</b> Day <b>30</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>19 Nov 1887</b>	9. AGE (In years last birthday) <b>72 yrs</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>	IF UNDER 24 HRS Hours <b>1</b> Min. <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Rheuben Nazelrod</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Sager</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>---</b>		INFORMANT <b>Mrs. Margie Sweeney---</b>		Address <b>Hall, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b>							
DUE TO (b) <b>Renal Failure</b>							
DUE TO (c) <b>CVA due to Arteriosclerotic Hypertension</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a))							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) <b>Upper Marlboro, Md</b>		(County) (State)	
21. I certify that I attended the deceased from <b>Nov 17</b> , 1959, to <b>30 Nov</b> , 1959, that I last saw the deceased alive on <b>29 Nov</b> , 1959, and that death occurred at <b>12:20 AM</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Dr. Robert Sasscer.</b>				DATE SIGNED <b>30 Nov 59</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Robert Sasscer.,</b>				Address (Street, city or town, state) <b>Upper Marlboro., Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/3/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Ft. Myer Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Thomas</b>				24a. REC'D BY REGISTRAR <b>DEC 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12867

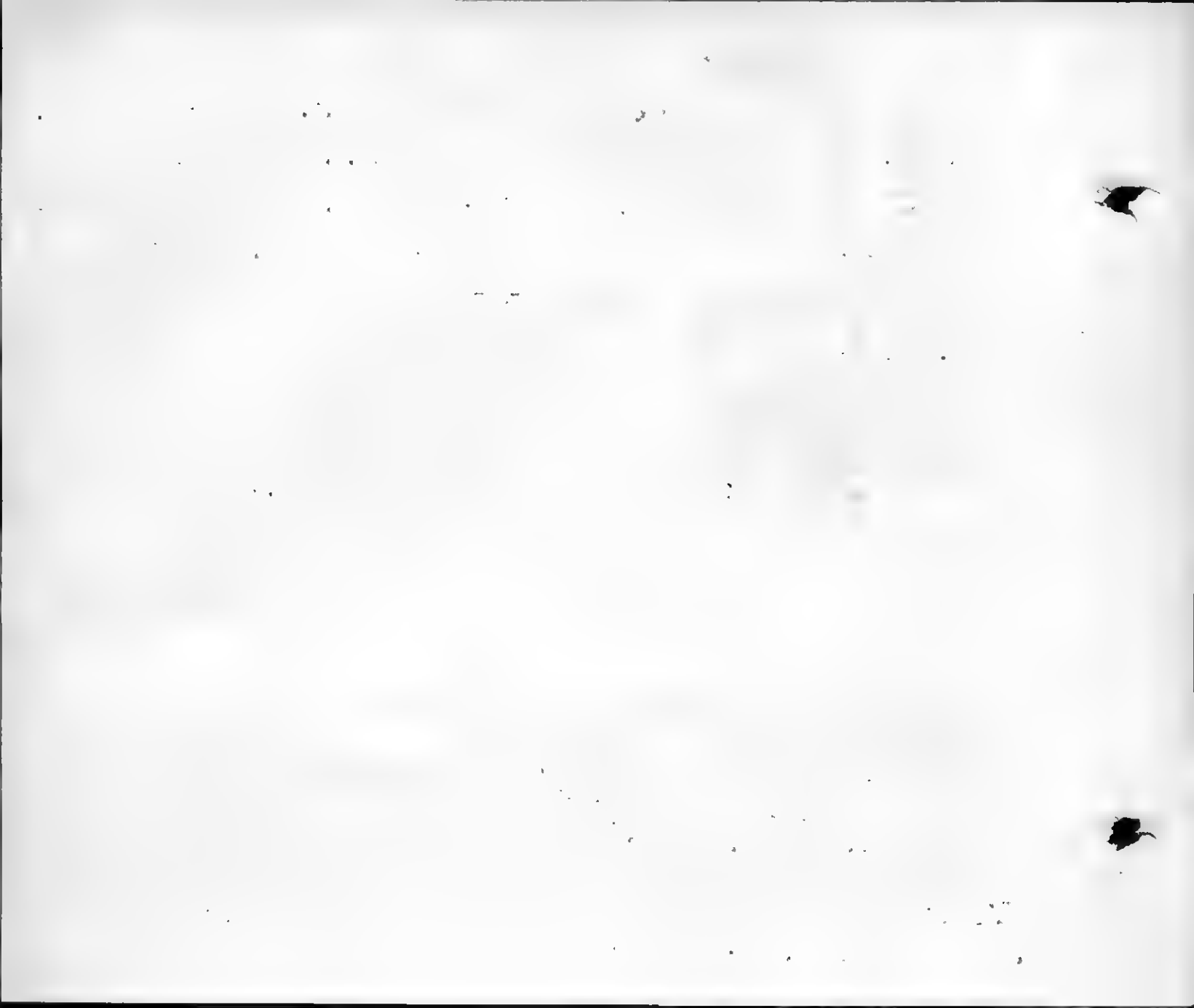
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>3 Days</b>		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>(Washington D.C.)</b> COUNTY <b>Prince George-Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Washington, D.C.) Parkland, Maryland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>19 Maryland Ave.</b>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>George B Boniface</b>		4. DATE OF DEATH Month Day Year <b>Nov. 19 19 59</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>7-31-10</b>		9. AGE (In years birth day) yrs. <b>49</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>19 59</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dep't. of Defense</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Missel Research</b>	
11. BIRTHPLACE (State or foreign country) <b>Charleston, S. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Edward Victor Boniface</b>		14. MOTHER'S MAIDEN NAME <b>Margaret G. Madden</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Hospital Records</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>510 Curthosis of liver, esophageal hemorrhage</b> DUE TO (b) <b>1 yr</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>✓</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>✓</b>		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>Nov 16</b> , 19 <b>59</b> , to <b>Nov 19</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Nov 19</b> , 19 <b>59</b> , and that death occurred at <b>10:00 PM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>1746 R St NW Wash DC</b>		DATE SIGNED <b>11/19/59</b>			
ACTUAL SIGNATURE <b>Donald W. Mitchell</b>		M.D.		PHYSICIAN'S NAME (Type) <b>Dr. Donald W. Mitchell</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-21-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Washington National</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>James T. Ryah, Inc.</b>		ADDRESS <b>317 Pa. Ave., SE DC</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 23 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

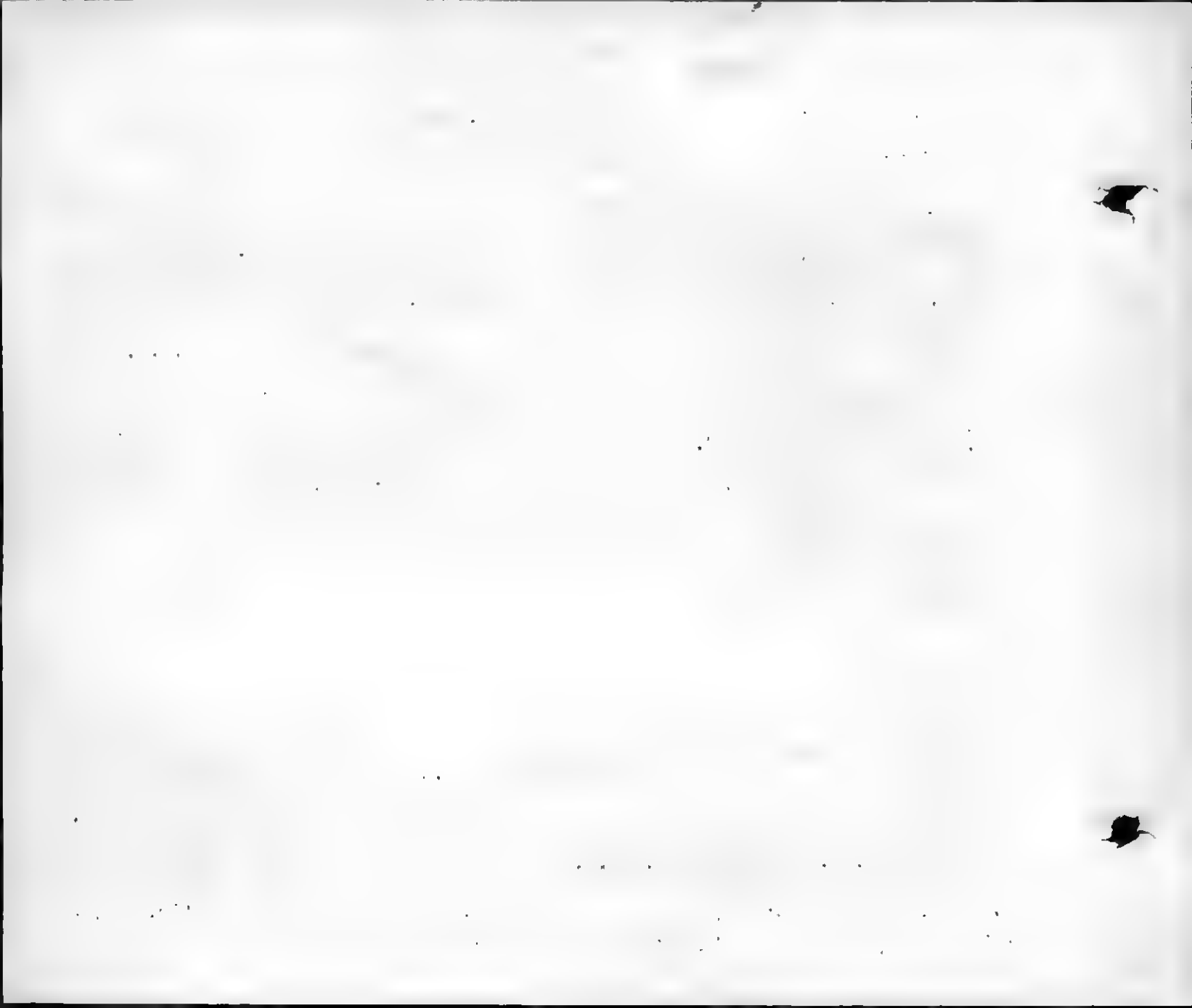
Reg. Dist. No.

12868

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesverly</b>		c. LENGTH OF STAY IN 1b <b>39 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lucy</b> Middle <b>Boone</b> Last <b>Boone</b>		4. DATE OF DEATH Month <b>Nov</b> Day <b>25</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Black</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>19 AUG 1959</b>
9. AGE (In years last birthday) <b>4</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>11</b> Hours <b>15</b> Min <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Boone</b>		14. MOTHER'S MAIDEN NAME <b>BARBARA OWENS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>FATHER</b>		Address <b>Upper Marlboro, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONCENTRIC MYOCARDIAL INFARCTION</b> 757.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>5:00A M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3001 Chesverly Ave Chesverly, Md.</b> DATE SIGNED _____ ACTUAL SIGNATURE _____ PHYSICIAN'S NAME (Type) <b>Dr. B. Van Gelderen, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-28-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mount Carmel</b>	22d. LOCATION (City, town, or county) (State) <b>Upper Marlboro, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Shirley R. Collins</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 30 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Christina S. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12869

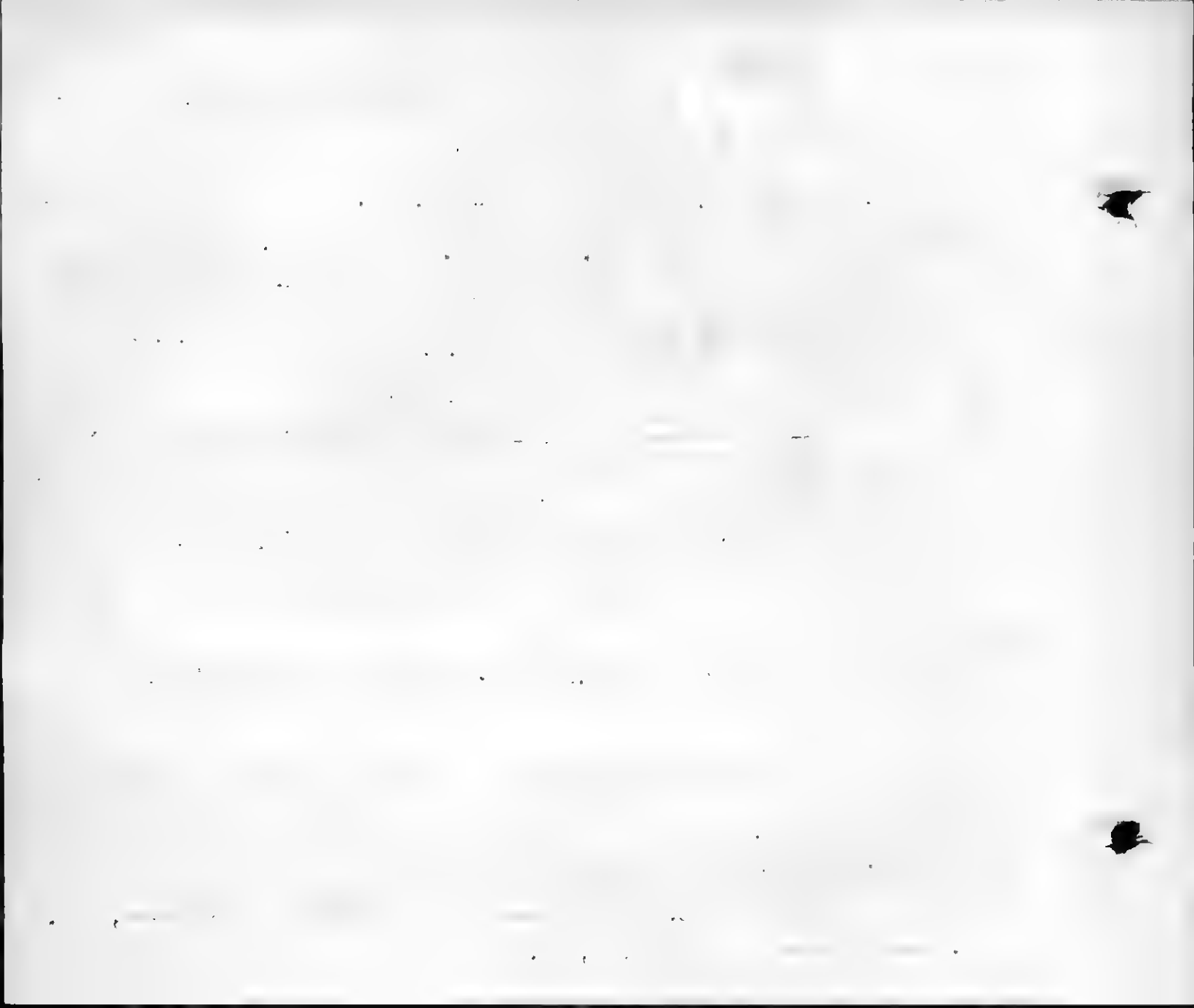
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>21 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edmonston</b> X		d. STREET ADDRESS / <b>5002-47th. Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>A.</b> Last <b>Brown.</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>7</b> Year <b>59</b> 19		5. SEX <b>male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>1-6-68</b>		9. AGE (In years last birthday) <b>91</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>		11. BIRTHPLACE (State or foreign country) <b>D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Brown</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Daugherty</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Elizabeth Vermillion</b> Address <b>Same as # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Incumones right lung</b> <b>733X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fracture left hip. Pathological</b> DUE TO (c) <b>11-3-59</b> <b>10-17-59</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Moving back + fall in bed, pathologic</b>	
20c. TIME OF INJURY Month. Day. Year Hour a.m. <b>10-17</b> 19 <b>59</b> p.m. <b>10-17</b> 19 <b>59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>10-17</b> 19 <b>59</b> , to <b>11-7</b> 19 <b>59</b> , that I last saw the deceased alive on <b>11-7</b> 19 <b>59</b> , and that death occurred at <b>12:19 PM</b> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>George H. Hagge</b> M.D. <b>3717-38th St</b>		DATE SIGNED <b>11-7-59</b>		ADDRESS (Street, city or town, state)		DATE SIGNED		DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Dr. G. Hagge</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/10/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 10 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12852

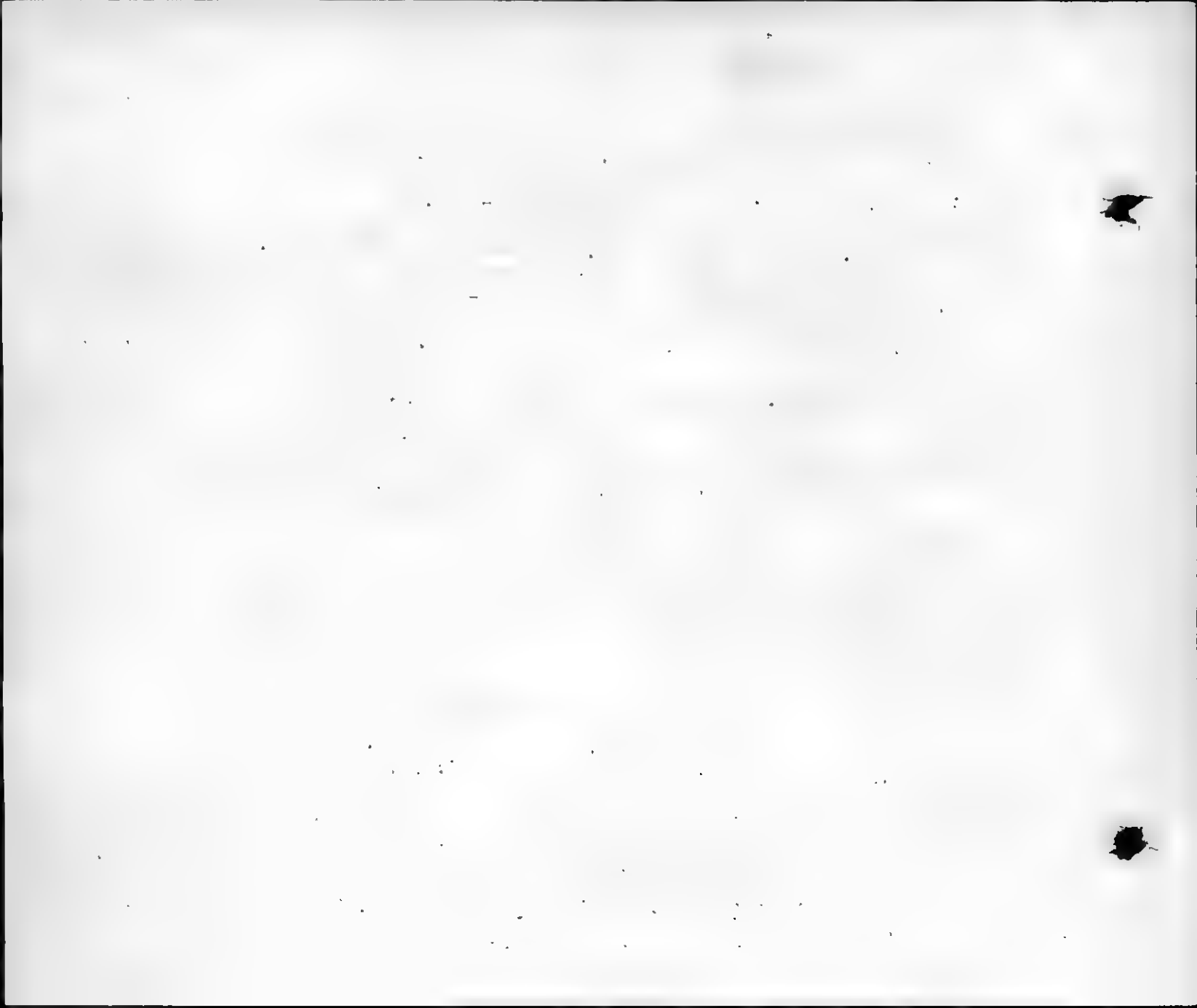
12870

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2 USUAL RESIDENCE (If deceased lived in a institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesley</b>			c. LENGTH OF STAY IN lb <b>20 min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cedar Heights</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>				d. STREET ADDRESS <b>908-64th Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Rosa</b> Middle <b>G.</b> Last <b>Brown</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>28</b> Year <b>59</b>					
5. SEX <b>Fem.</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-2-16</b>	9. AGE (In years last birthday) <b>43</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James H. Brown</b>				14. MOTHER'S MAIDEN NAME <b>Emma L. Green</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT <b>Marie Tilghman-sister 680 Walker Mill Road, S.E.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>491X</b> DUE TO <b>Bacterial pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 28</b> , 19 <b>59</b> to <b>Nov. 28</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Nov. 28</b> , 19 <b>59</b> , and that death occurred at <b>9:10 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Ronald S. Fleischer</b> M.D.				ADDRESS (Street, city or town, state) <b>1731 W. Washington</b> DATE SIGNED <b>1/28/59</b>			
PHYSICIAN'S NAME (Type) <b>RONALD S. FLEISCHER</b>				ADDRESS <b>1731 W. Washington</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>12-2-59</b>		<b>12-2-59</b>		<b>mt Olivet</b>		<b>Washington D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry S. Washington</b>				ADDRESS <b>467 N St NW</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 4 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frame</b>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

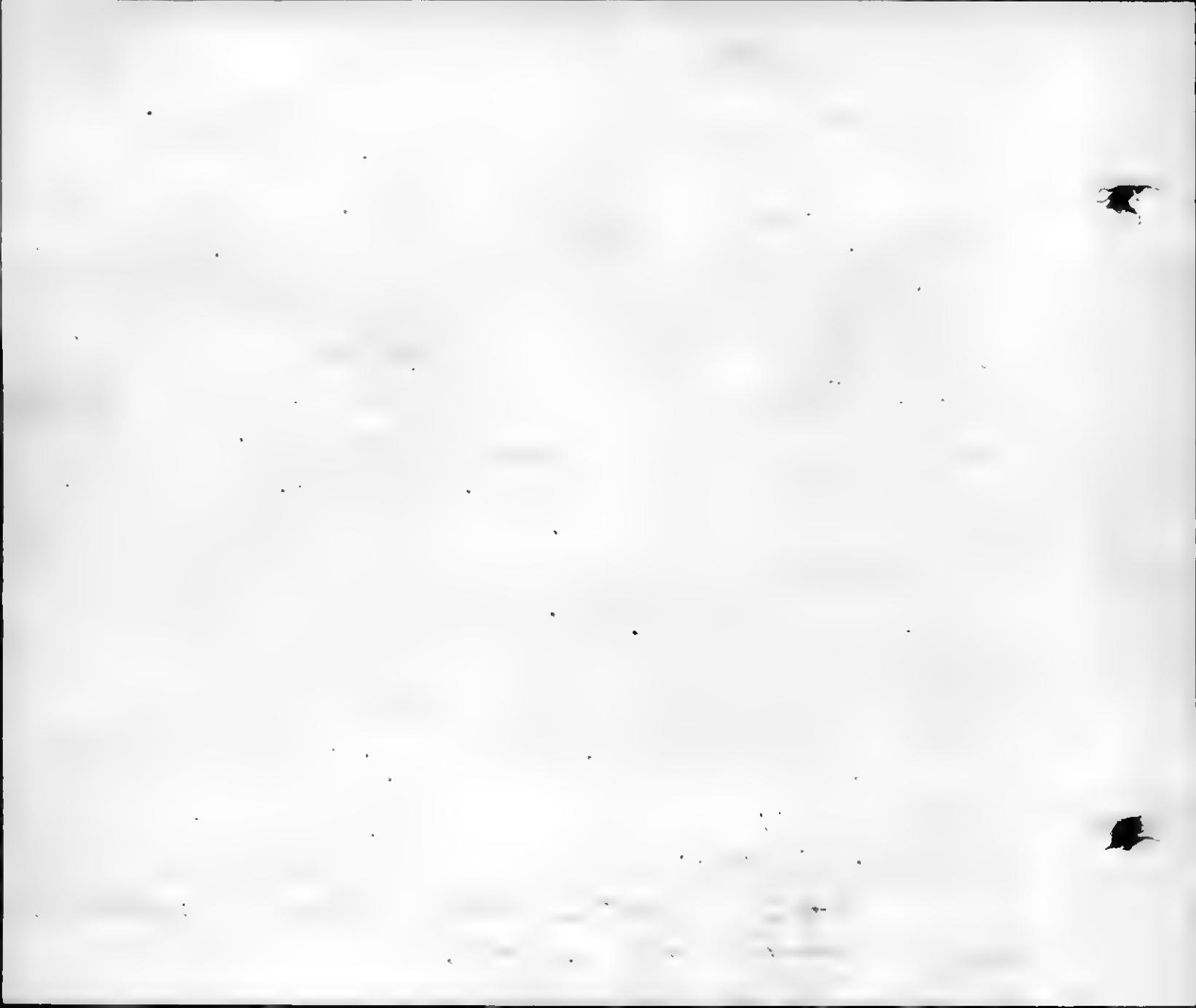
12871

## CERTIFICATE OF DEATH

12853

Reg. Dist. No.

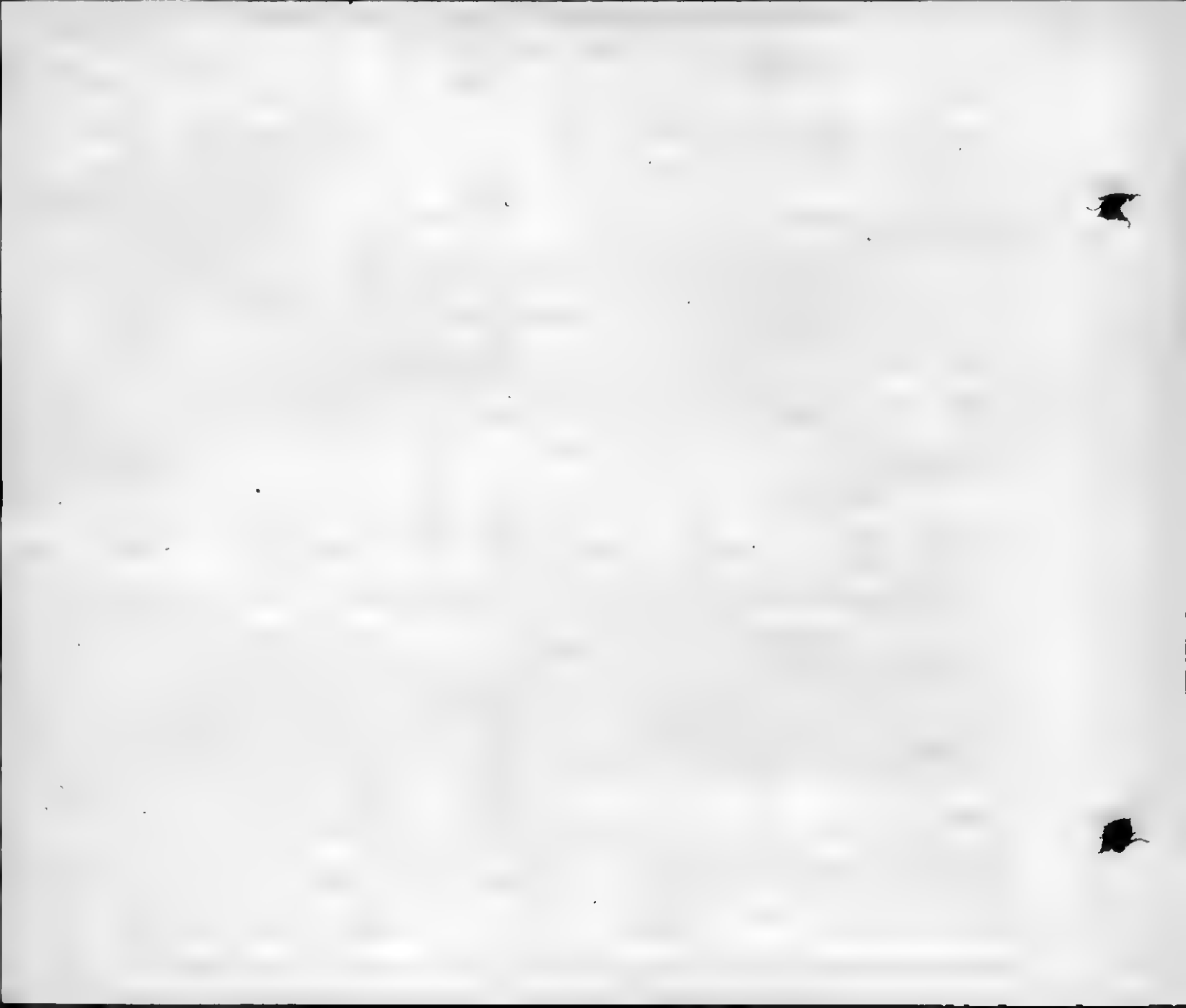
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesley</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington .27</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>		d. STREET ADDRESS <b>7191 Ritchie St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Alice</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>11</b> Year <b>19 59</b>	
5. SEX <b>Fem.</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <b>67</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Lewis</b>		14. MOTHER'S MAIDEN NAME <b>Louise Green</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>—</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, acute</b> DUE TO (b) <b>Diabetes mellitus</b> DUE TO (c) <b>—</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized atherosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 4</b> , 19 <b>59</b> , to <b>Nov. 11</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>November 11</b> , 19 <b>59</b> , and that death occurred at <b>9:40 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Till Bergemann</b>		ADDRESS (Street, city or town, state) <b>9314 Leila St. Hyattsville</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Till Bergemann</b>		DATE SIGNED <b>Nov. 11</b>	
22. BURIAL, CREMATION, REMOVAL (Specify) <b>1146-59</b>		22b. DATE THEREOF <b>1146-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt Carmel</b>		22d. LOCATION (City, town, or county) (State) <b>Upper Marlboro Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry J. Washington</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 18 '59</b>	
ADDRESS <b>467 N St NE</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneass</b>	



12872  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 1000 2 1111 3-55 12/3/59 LWK  
 12854  
 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL 4'</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LAUREL SANITARIUM</u>		4. STREET ADDRESS <u>386 MAIN STREET</u>	
3. NAME OF DECEASED (Type or print) First <u>DORA</u> Middle <u>A</u> Last <u>BYERLY</u>		4. DATE OF DEATH Month <u>NOV</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 21-1874</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	
11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES ALBERT CLARK</u>		14. MOTHER'S MAIDEN NAME <u>MARY ADELAIDE BUNDY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>HOSPITAL RECORDS LAUREL SANITARIUM</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure (434.1)</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic heart disease (420.1)</u> DUE TO (c) <u>many years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile dementia (arteriosclerotic)</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <u>8</u> p. m. Month <u>Nov</u> Day <u>27</u> Year <u>1959</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>home</u> , 19 <u>56</u> to <u>Nov-27-1959</u> , that I last saw the deceased alive on <u>Nov-27-1959</u> , and that death occurred at <u>8:10 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Laurel Sanitarium</u> DATE SIGNED <u>11-27-59</u> ACTUAL SIGNATURE <u>Frika P. Kraemer</u> M.D. <u>Laurel Sanitarium</u> PRINTED NAME (Type) <u>FRICA P. KRAEMER LAUREL MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/1/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Calverton National Calverton Virginia</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Willard K. ...</u>		24a. REC'D BY REGISTRAR <u>DEC 1 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12873

## CERTIFICATE OF DEATH

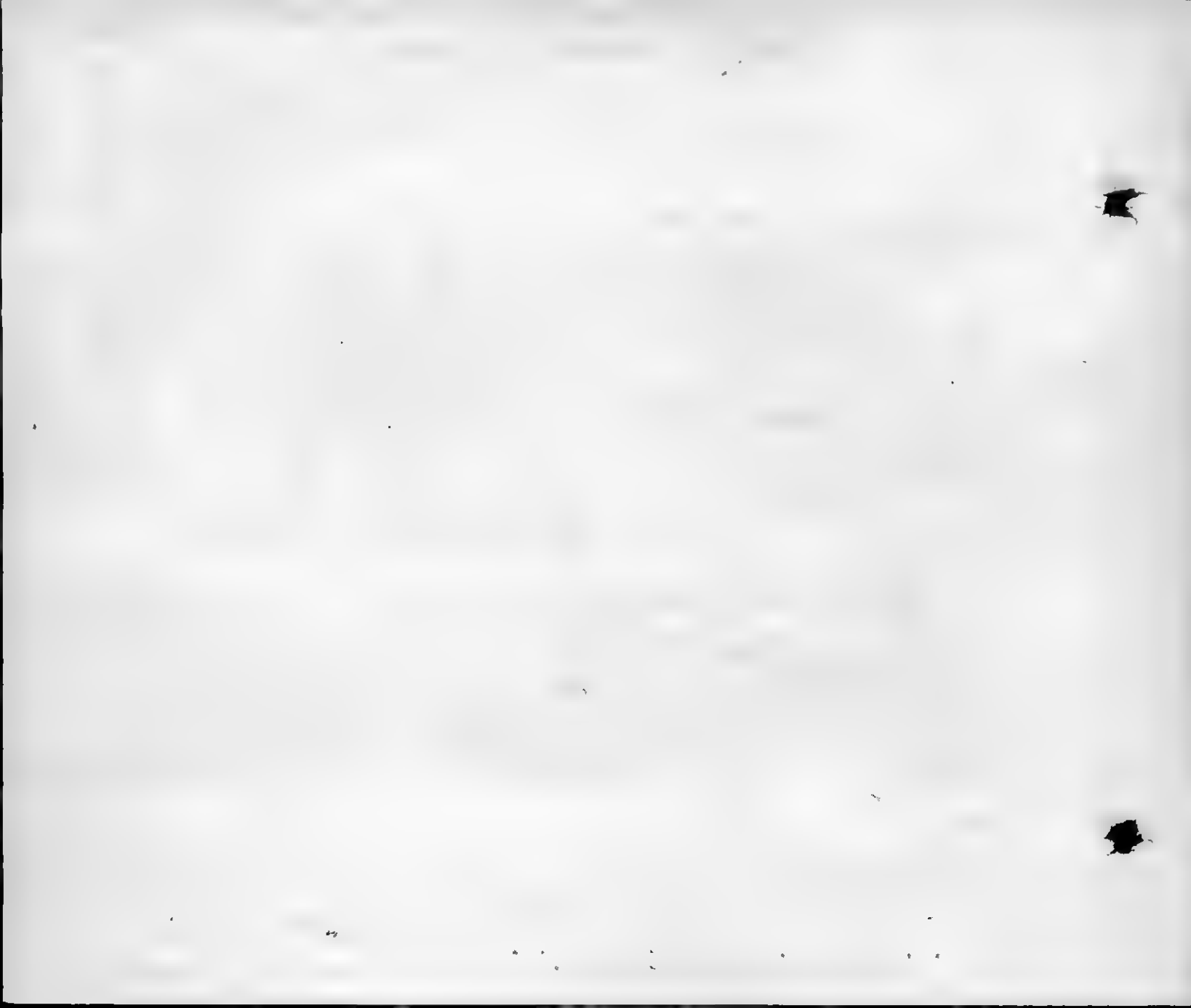
12855

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Capitol Heights</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Capitol Heights</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>807 58th Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Sophie</i> First <i>M.</i> Middle <i>Caahill</i> Last		4. DATE OF DEATH Month <i>Nov.</i> Day <i>12</i> Year <i>1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8.8.1890</i>
9. AGE (In years last birthday) <i>69</i> yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Germany</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Herman Rosenfeld</i>	
14. MOTHER'S MAIDEN NAME <i>BERTHA STERIN</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>493-24-0582</i>		17. INFORMANT <i>John G Caahill</i> Address <i>807 58th Ave Capitol Heights Maryland</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>154X</i> DUE TO <i>Generalized Metastasis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Adenocarcinoma of rectum</i> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>September 1957</i> to <i>11-12-1959</i> , that I last saw the deceased alive on <i>11-12-1959</i> , and that death occurred at <i>11 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Peter Duus</i> M.D.		ADDRESS (Street, city or town, state) <i>6124 Central Ave.</i> DATE SIGNED <i>11-12-59</i>	
PHYSICIAN'S NAME (Type) <i>PETER DUUS</i>		<i>Capitol Heights Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11/16/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mount Olivet Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co.</i> ADDRESS <i>2901 14th St. N.W. Washington, D.C.</i>		24a. REC'D BY REGISTRAR <i>DATE NOV 16 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Curtis &amp; Kraus</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

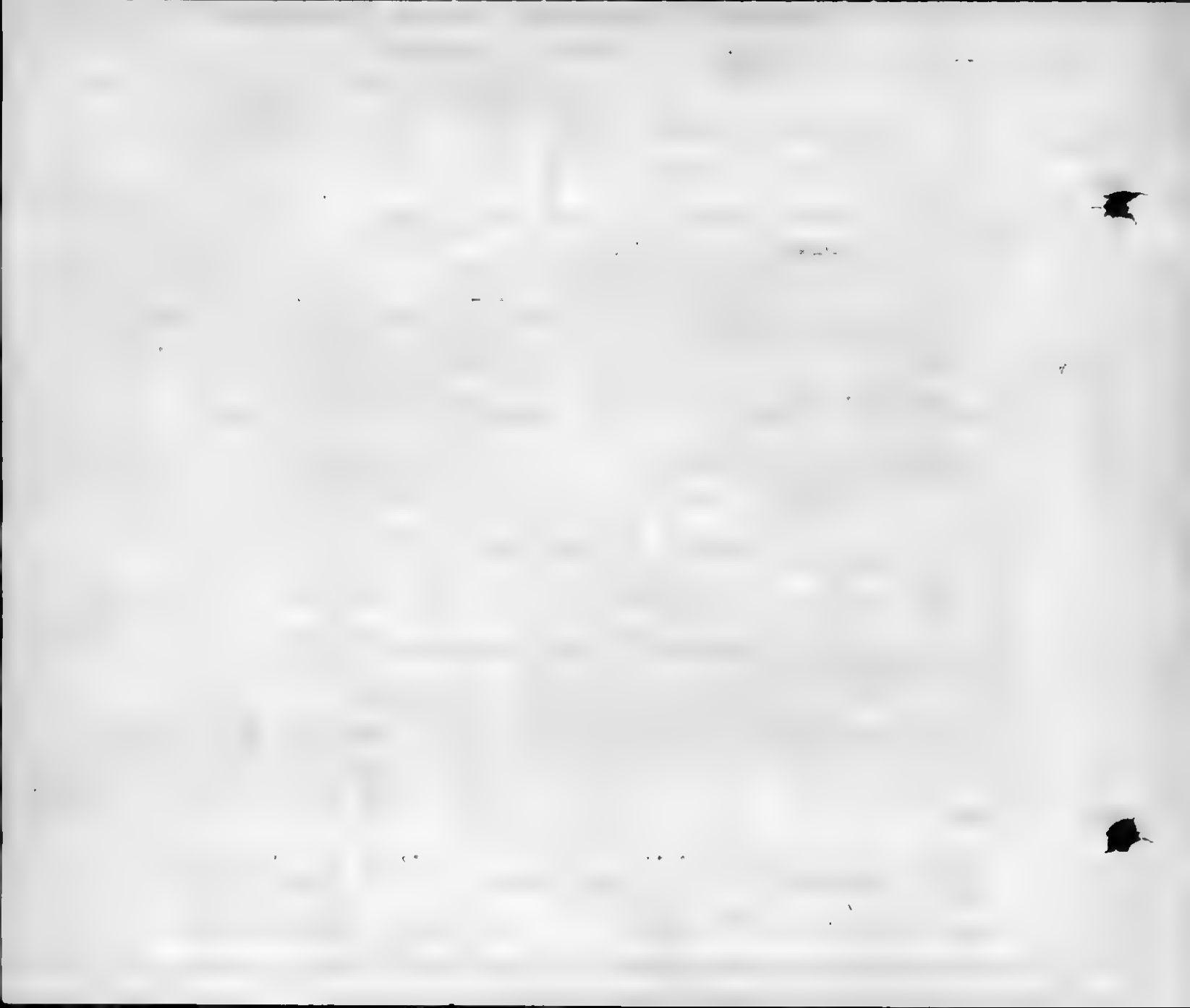
12856

12874

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Beltsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital				d. STREET ADDRESS 11426 Cherry Hill Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Violett Last Christine A Carroll				4. DATE OF DEATH Month November Day 16 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-7-11		9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George W. Carroll				14. MOTHER'S MAIDEN NAME Cora Lee Lipstrap			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-38-3386		17. INFORMANT Hospital Record Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 17 DUE TO Cachexia and hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of the cervix of uterus DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 7-11-59, to 11-16-59, that I last saw the deceased alive on 11-16-59, and that death occurred at 9:03 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Theodore Zagarra, M.D.				ADDRESS (Street, city or town, state) DATE SIGNED 11-16-59			
PREPARE NAME (Type) Theodore Zagarra M.D., 4404 Queensbury Rd., Riverdale, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/19/59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home, Inc. Mt. Rainier, Md.				24a. REC'D BY REGISTRAR DATE NOV 20 '59		24b. REGISTRAR'S SIGNATURE	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the bur of transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

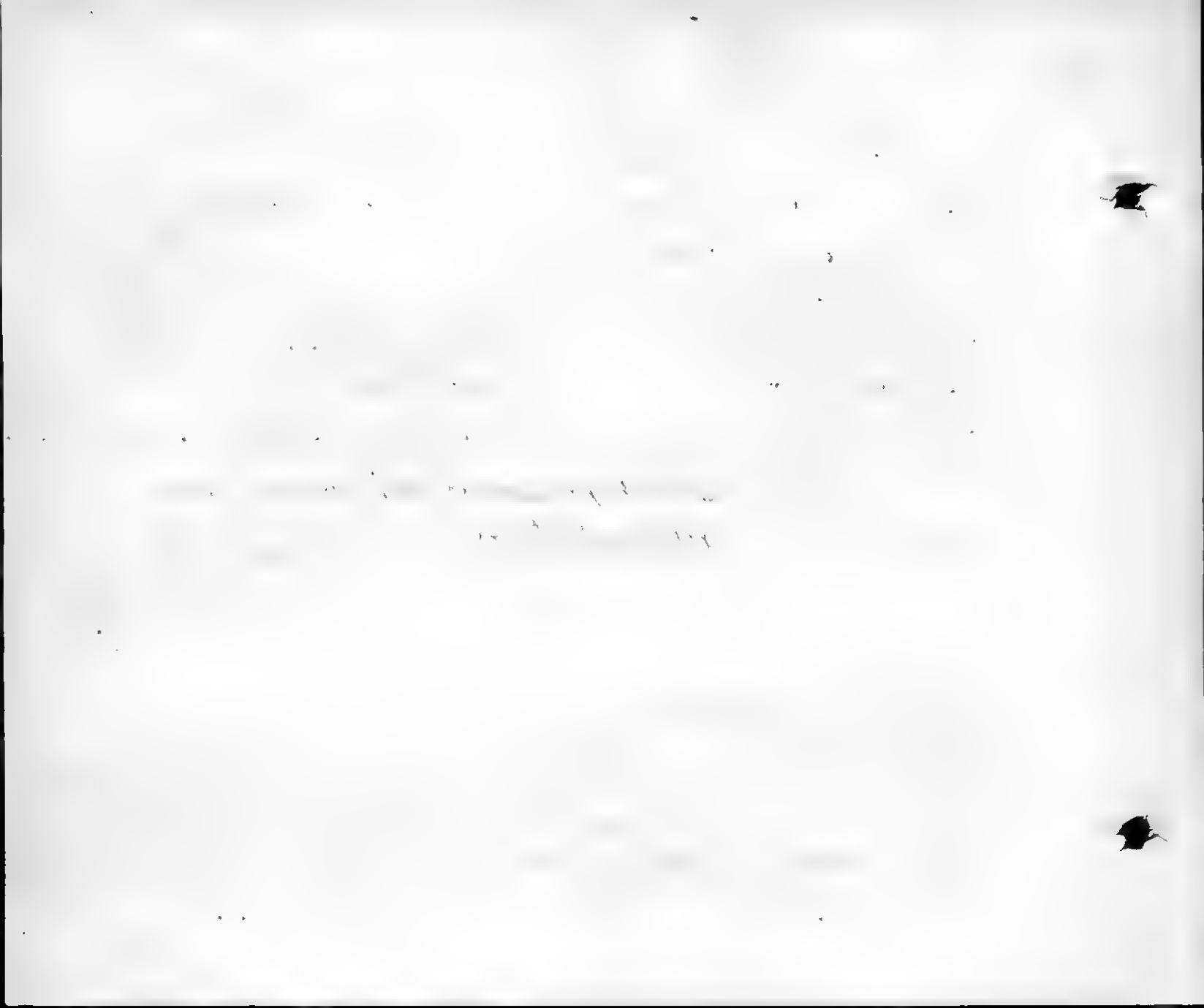
12875

## CERTIFICATE OF DEATH

12857

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN Ib <b>8 hrs</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bladensburg</b> d. STREET ADDRESS <b>14909 Quincy Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Roy</b> Middle <b>Ernest</b> Last <b>Carter</b>		4. DATE OF DEATH Month <b>Nov</b> Day <b>18</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9 Feb 1909</b>
9. AGE (In years last birthday) <b>50</b>		10. IF UNDER 1 YEAR Months <b>50</b> Days <b>50</b> Hours <b>50</b> Min <b>50</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Auto Body</b>	
11. BIRTHPLACE (State or foreign country) <b>Yancy County, N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Eugene Carter</b>		14. MOTHER'S MAIDEN NAME <b>Clara Blankenship</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Ernest E. Carter, 4908 Quincy St. Bladensburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>492x</b> DUE TO <b>Bronchopneumonia with abscess formation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Malignant</b> DUE TO <b>Malignant</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 18, 1959</b> to <b>Nov 18, 1959</b> , that I last saw the deceased alive on <b>Nov 18, 1959</b> , and that death occurred at <b>5:00 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Donald F. ...</b>		ADDRESS (Street, city or town, state) <b>432 ...</b>	
PHYSICIAN'S NAME (Type) <b>RONALD S. FREISCHER</b>		DATE SIGNED <b>11/19/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 21/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Unknown</b>		22d. LOCATION (City, town, or county) (State) <b>Asheville, N.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. H. Chambers, Riverdale, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 24 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. ...</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12858

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro x	
c. LENGTH OF STAY IN 1b Dead on arrival			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS Main Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Carry Mable Chaney		4. DATE OF DEATH Month Day Year November 30, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1886
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Sears		14. MOTHER'S MAIDEN NAME Ella - ? - Last name unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Louis Henry Chaney, Upper Marlboro, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (b) DUE TO (c) stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James I. Boyd		DATE SIGNED November 30, 1959	
EXAMINER'S NAME (Type) James I. Boyd		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/3/59	
22c. NAME OF CEMETERY OR CREMATORY Smithville Cemetery		22d. LOCATION (City, town, or county) (State) Smithville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ritchie Bros. Funeral Home- Upper Marlboro, Md.		24. REC'D BY REGISTRAR DEC 7 '59	
24b. REGISTRAR'S SIGNATURE			

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA-3. Page 5 may be retained for your file. For a burial, cremation, or removal, file pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

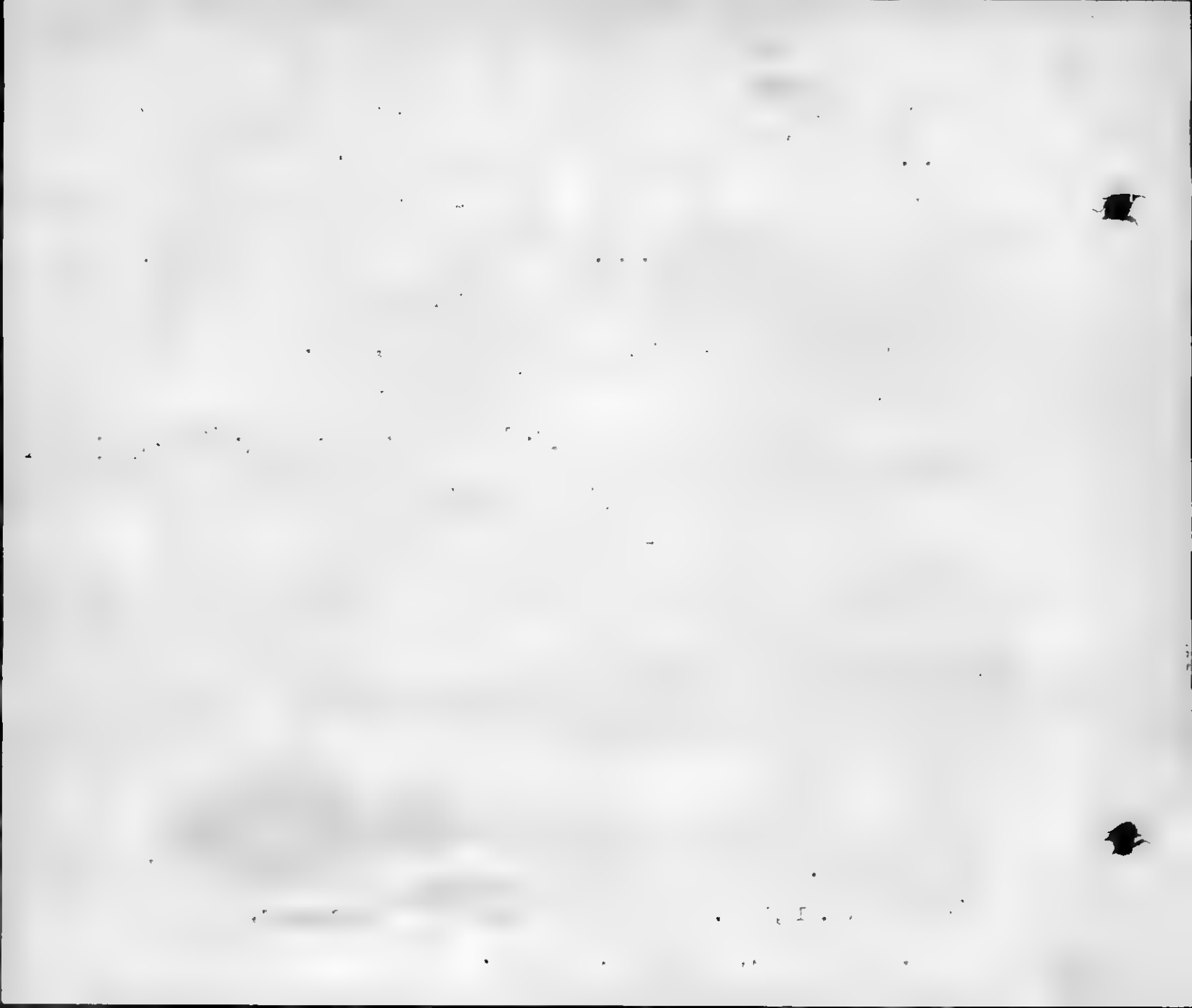
Forms 10a, 10b & 22b, Form G-253 12/8/59.cac. Reg. Dist. No.

13996

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>T.B.</b> c. LENGTH OF STAY IN 1b <b>Transient</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Dobson's Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Connecticut</b> b. COUNTY <b>Hartford</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Manchester Green</b> d. STREET ADDRESS <b>562 East Middle Turnpike</b> e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>AARON</b> Middle <b>(N.M.N.)</b> Last <b>COOK</b>		4. DATE OF DEATH Month <b>November</b> Day <b>11th</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 6th, 1909</b>
9. AGE (in years last birthday) <b>50</b> yrs		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Security Trader (see below)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brokerage (see below)</b>	
11. BIRTHPLACE (State or foreign country) <b>Manchester, Conn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Garage &amp; gas station operator</b> <b>Arthur Cook</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Luce</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mrs. Elizabeth L. Cook, 562 E. Middle Tpke. Manchester Green, Conn.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive Heart Failure</b> DUE TO (b) <b>Cardio-vascular renal disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b> EXAMINER'S NAME (Type) <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>Nov. 11/1959</b>	
22a. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> DATE THEREOF <b>Burial Nov. 18, 1959.</b>	22b. NAME OF CEMETERY <b>East Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Manchester, Connecticut</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. CHAMBERS CO., Riverdale, Maryland.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 16 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur &amp; Thane</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12877

CERTIFICATE OF DEATH

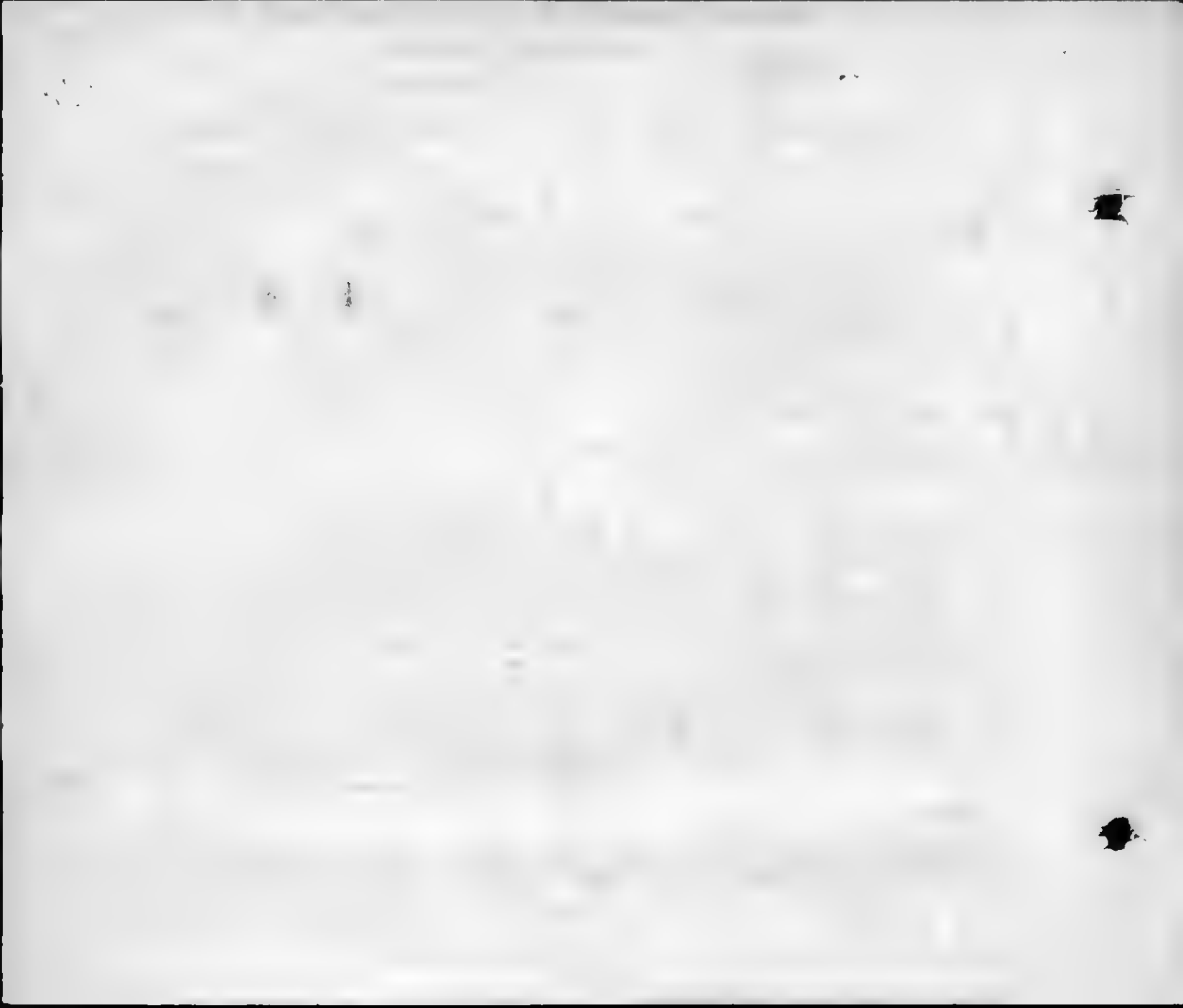
Reg. Dist. No.

12859

1. PLACE OF DEATH a. COUNTY <u>Pr. George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Pr. George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u>				c. LENGTH OF STAY IN 1b <u>20 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3704 Taylor St.</u>				e. STREET ADDRESS <u>3704 Taylor St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>P.</u> Last <u>Cusick</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>27</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 19, 1888</u> 71 yrs.	
9. AGE (In years last birth day) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H-wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Alexander Reamy</u>				14. MOTHER'S MAIDEN NAME <u>Maggie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or date of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>John R. Cusick, Jr.</u>				Address <u>Same as #2.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>						<u>1 week</u>	
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(b) <u>Arteriosclerosis</u>	
DUE TO						<u>5 years</u>	
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Mar 10, 1957</u> to <u>Nov 27, 1959</u> ; that I last saw the deceased alive on <u>Nov 26, 1959</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)						DATE SIGNED	
ACTUAL SIGNATURE <u>J. Raymond Raedy</u>				M.D. <u>3701 Leland St. Chevy Chase, Md.</u> <u>11-27-59</u>			
PHYSICIAN'S NAME (Type) <u>J. Raymond Raedy</u>				3701 Leland St., Chevy Chase, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11-30-1959</u>		<u>FT Lincoln Cemetery</u>		<u>Bladensburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u>				ADDRESS <u>5801 Cleveland Ave RIVERDALE, MD</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 1, '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hunt</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

12860

12927

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges <sup>1</sup> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL—Upper Marlboro		c. LENGTH OF STAY IN 1b 50 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL—Upper Marlboro	
3. NAME OF DECEASED (Type or print) Stella Juliette Danenhower		4. DATE OF DEATH Nov 22 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1884
9. AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife—Tobacco Farming		10b. KIND OF BUSINESS OR INDUSTRY Own Home—Farm	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Edward D. Danenhower, Jr.—Maryland;		Address Upper Marlboro	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Coronary Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 22 hrs 2 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 17 hrs, 1959, to Nov 22, 1959, that I last saw the deceased alive on Nov 26, 1959, and that death occurred at 10 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE R. B. Sasscer		UPPER MARLBORO, MD NOV 27 1959	
PHYSICIAN'S NAME (Type) R. B. Sasscer, M.D.		Upper Marlboro, Maryland:	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/30/59	22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home—Marlboro, Md.		24a. REC'D BY REGISTRAR DATE DEC 1 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 10/57



12928  
CERTIFICATE OF DEATH

Reg. Dist. No.

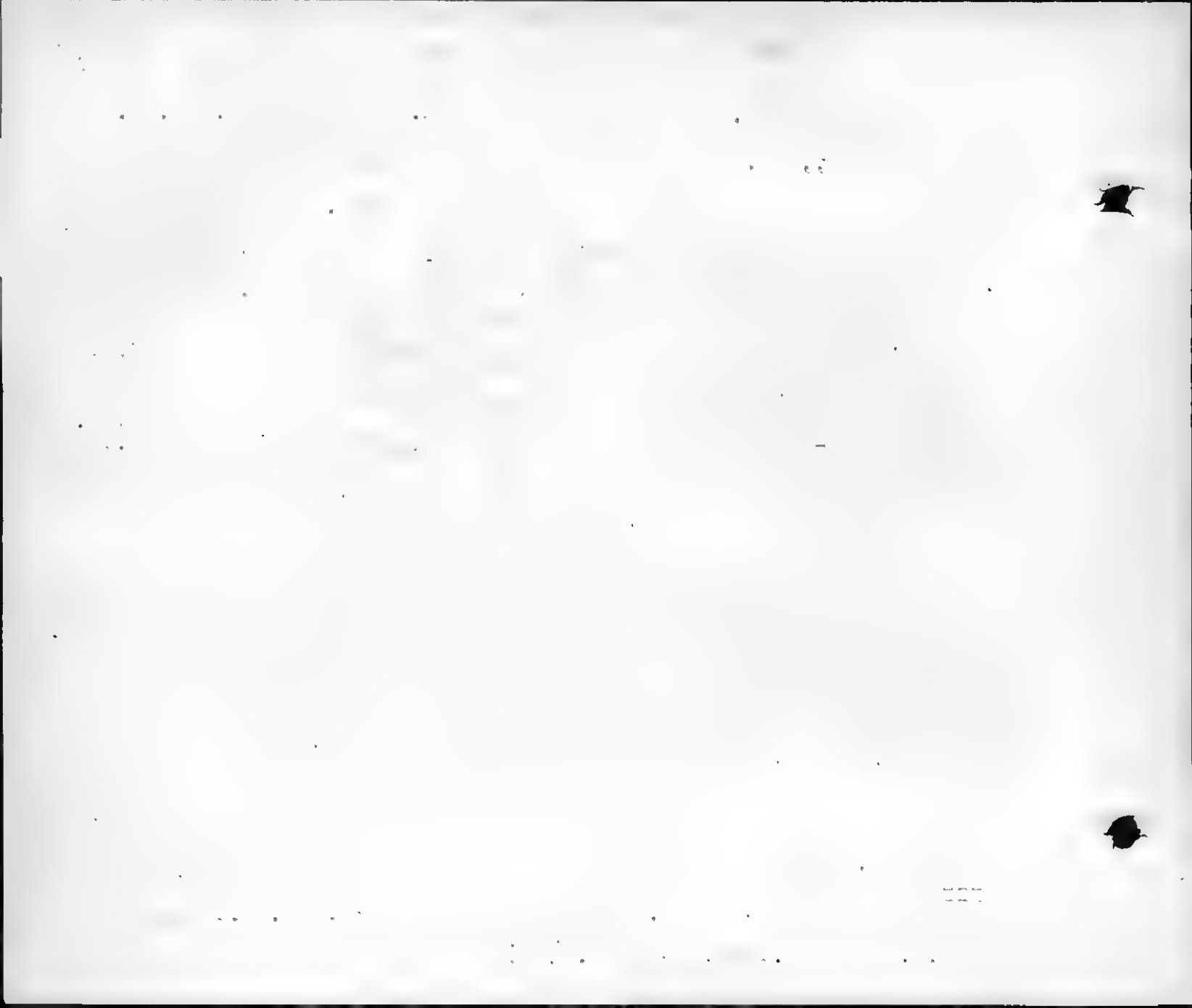
12861

1. PLACE OF DEATH a. COUNTY <u>Prince George's Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Pr. Geo. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover Hills, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover Hills</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First <u>Isabel</u> Middle <u>Lewis</u> Last <u>Davis</u>		Month <u>November</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/22/1883</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Walker Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Jane Page</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Archie Marchis D. Davis</u>		Address <u>Hills, Md.</u> <u>4402 72nd Ave., Landover</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>  </u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>  </u> 19 <u>  </u> to <u>  </u> 19 <u>  </u> , that I last saw the deceased alive on <u>  </u> 19 <u>  </u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>  </u> M.D. <u>  </u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>  </u>	
PHYSICIAN'S NAME (Type) <u>F.E. Musser</u>			
22a. BURIAL, CREMATON, REMOVAL (Specify) <u>cremation</u>	22b. DATE THEREOF <u>11/10/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Pr. Geo. Co., Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 9 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Colin S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

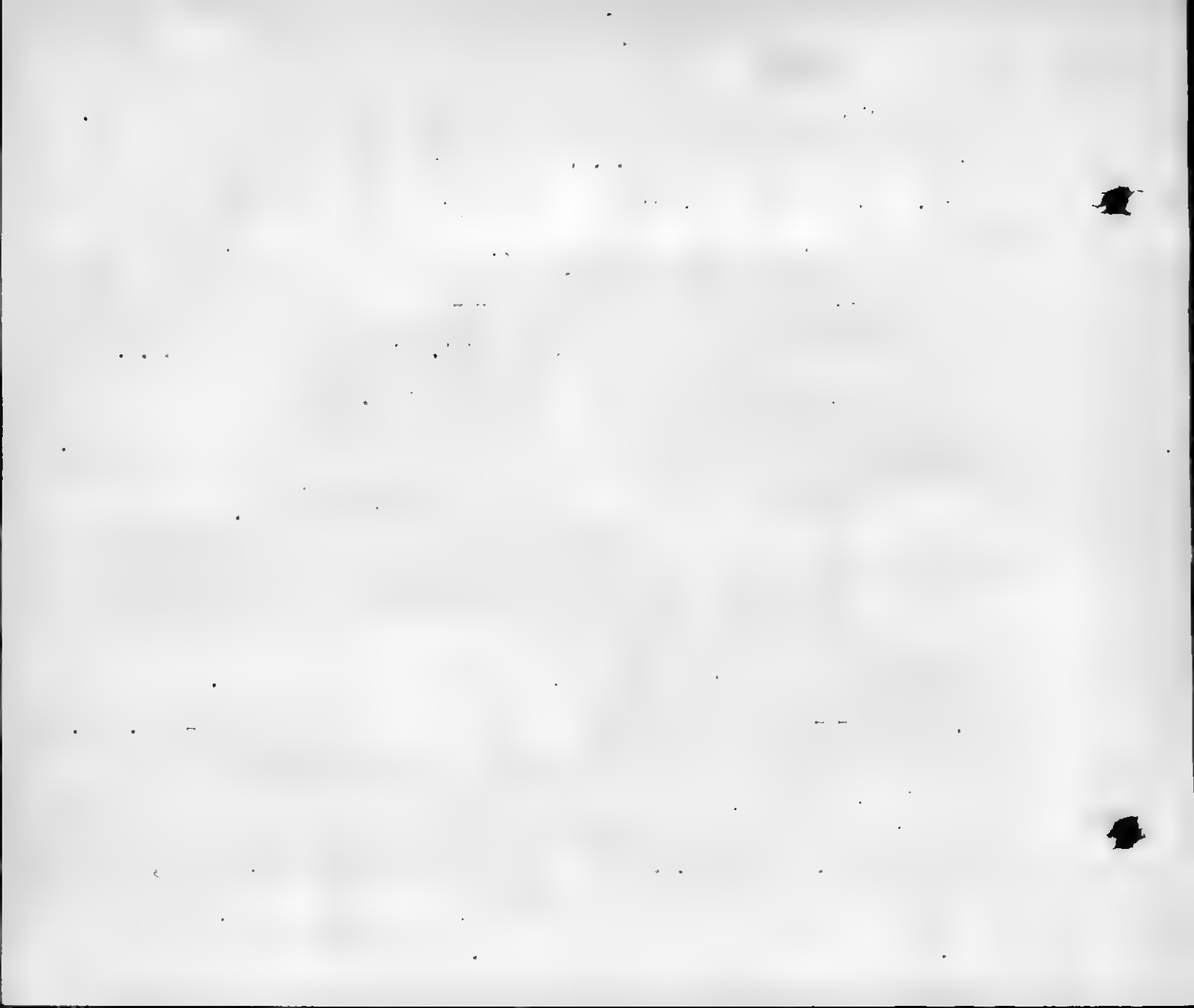
12862

Reg. Dist. No.

12878

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>East Riverdale</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>David Robert Dennis</b>		4. DATE OF DEATH Month <b>November</b> Day <b>6</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-2-41</b>
9. AGE (In years last birthday) <b>18</b> yrs.		10. UNDER 1 YEAR Months <b>18</b> Days <b>19</b> Min <b>59</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stock clerk</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Department store</b>	
13. BIRTHPLACE (State or foreign country) <b>Dist. of Columbia</b>		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. FATHER'S NAME <b>Charles Joseph Dennis</b>		16. MOTHER'S MAIDEN NAME <b>Maudie F. Reh</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		18. SOCIAL SECURITY NO. <b>Charles Joseph Dennis; same address as #2.</b>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture dislocation of cervical vertebra and fractured skull and compression of chest.</b> Conditions, if any, which gave rise to immediate cause (b) <b>Automobile accident</b> (c) <b>DUE TO</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Interval between onset and death</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger in an automobile that turned over.</b>	
20c. TIME OF INJURY Month, Day, Year <b>10:55 p.m. 11-6-59 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Berwyn Heights- Pr. Geo. Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		DATE SIGNED <b>November 9, 1959</b>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>nov 11, 1959</b>	
22c. NAME OF CEMETERY OR CREMATOR <b>Washington National</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		24. REC'D BY REGISTRAR <b>NOV 12 '59</b>	
ADDRESS <b>Hyattsville, Maryland.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur P. Kline</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

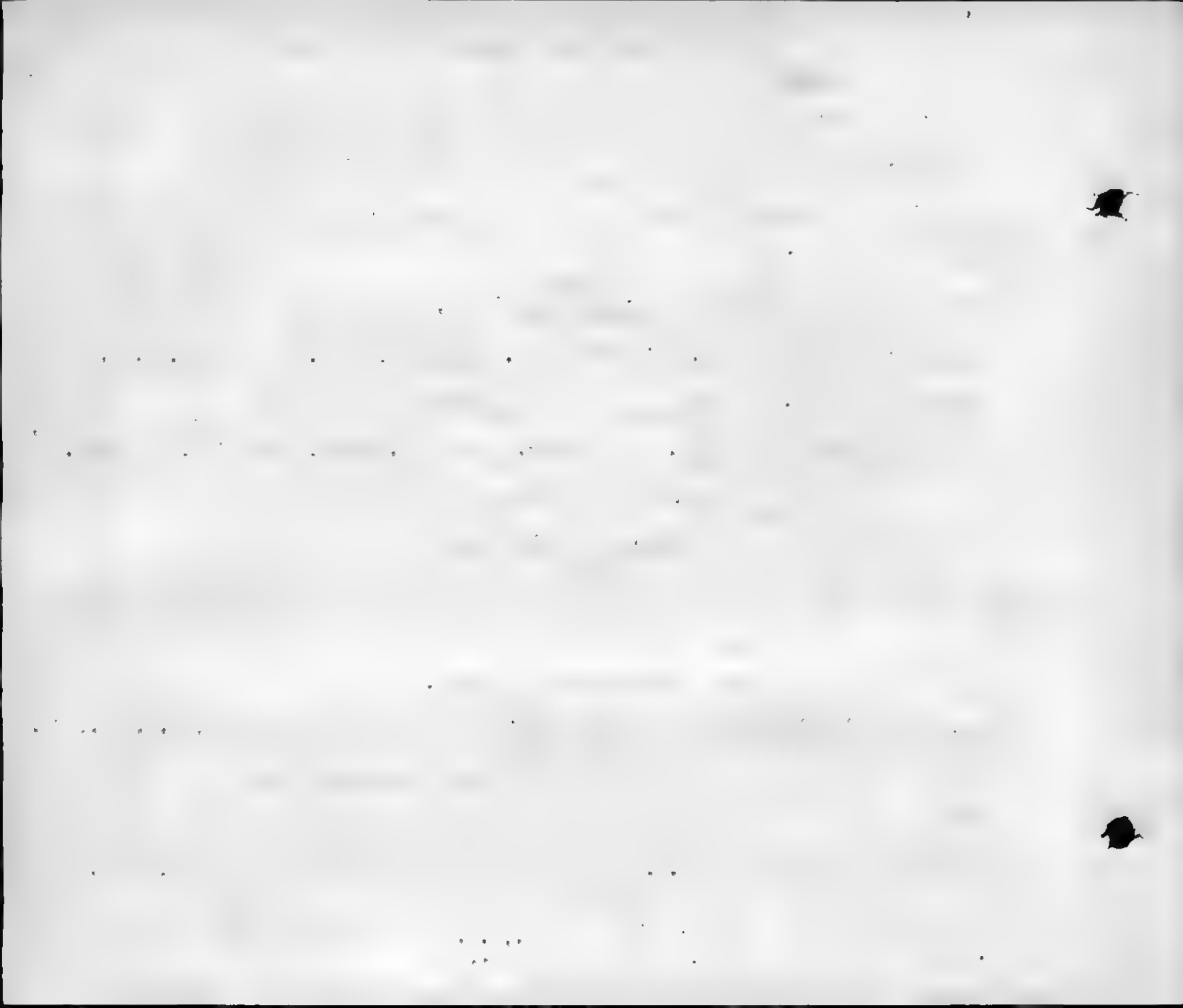
12863

12929

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b> b. CITY OR TOWN (If outside corporate limits, write R.U.R.A. and give nearest town) <b>Upper Marlboro</b> c. LENGTH OF STAY IN 1b <b>Upper Marlboro</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George County Jail</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write R.U.R.A. and give nearest town) <b>Oxen Hill</b> d. STREET ADDRESS <b>6149 Charles Way</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ELMER CECIL DUCKETT</b>		4. DATE OF DEATH Month <b>November</b> Day <b>14</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> <b>Married</b>	8. DATE OF BIRTH <b>April 13, 1905</b>	9. AGE (In years last birthday) <b>54</b> yrs.	10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>St. Elizabeth Hosp. Hartford, Tenn.</b>		11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>	
13. FATHER'S NAME <b>Samuel P. Duckett</b>		14. MOTHER'S MAIDEN NAME <b>Mattie Clark</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Herbert G. Clark, Oxen Hill, Maryland.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and Shook</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Gun Shot wound in Chest</b> (c) <b>Gun Shot wound in Chest</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Gun Shot wound in Chest</b> INTERVAL BETWEEN ONSET AND DEATH					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Shot while resisting Arrest.</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year <b>11/ 14/ 59</b> Hour <b>9:40</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Jail</b>	
20f. (City or town) <b>Upper Marlboro, P.G.Cty., Md.</b>		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input checked="" type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>November 16, 1959.</b>			
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-17-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	
22d. LOCATION (City, town, or county) <b>Switland Md</b>		22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wash., D.C.</b>		24a. REC'D BY REGISTRAR <b>NOV 18 '59</b>		24b. REGISTRAR'S SIGNATURE <b>W. S. P. P.</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

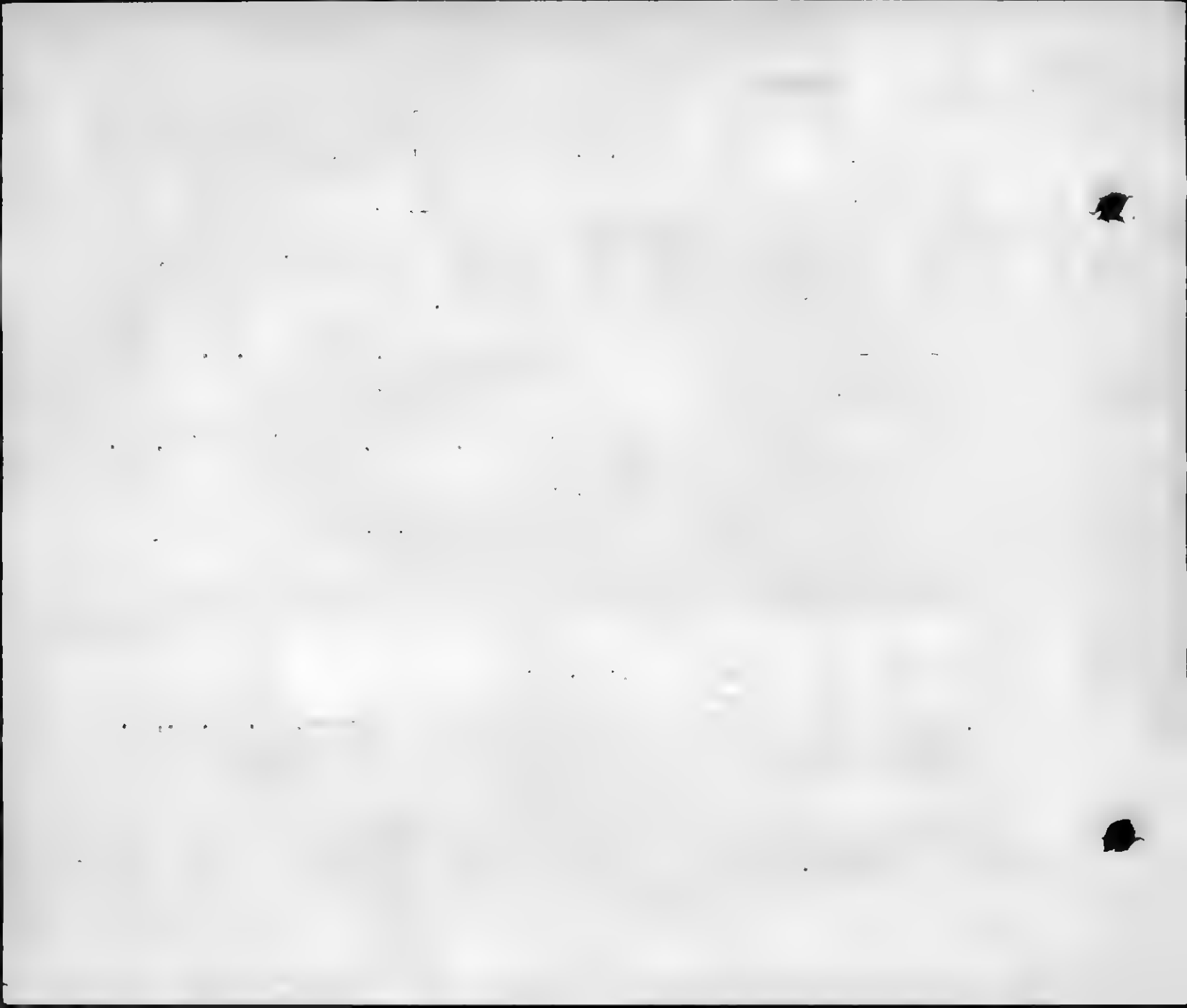
12864

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b>		c. LENGTH OF STAY IN 1b <b>Transient</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>In front of Fire House</b>		e. STREET ADDRESS <b>Tracey's Landing</b>	
3. NAME OF DECEASED (Type or print) <b>EVERETT</b> First <b>NICHOLAS</b> Middle <b>EASTON</b> Last		4. DATE OF DEATH Month <b>November</b> Day <b>5th</b> Year <b>19 59</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 5th, 1925</b>	
9. AGE (In years last birthday) <b>34</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>19</b> Hours <b>59</b> Min	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer--Self-employed</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
13. BIRTHPLACE (State or foreign country) <b>Chaneyville, Calvert Co. Md.</b>		14. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. FATHER'S NAME <b>Richard Henry Easton</b>		16. MOTHER'S MAIDEN NAME <b>Helen Mamie Young</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		18. SOCIAL SECURITY NO <b>Unknown</b>	
19. ADDRESS <b>Richard H. Easton, Tracey's Landing, Md.</b>		20. INTERVAL BETWEEN ONSET AND DEATH	
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage &amp; shock</b> <b>981X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gunshot wounds of chest and abdomen</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
22. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		23. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Shot during altercation</b>	
24. TIME OF INJURY Month, Day, Year <b>9:00</b> <b>11/5/</b> <b>19 59</b>		25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
26. (City or town) <b>Croome, Pr. Geo. Co., Md.</b>		27. (County) (State)	
28. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>		DATE SIGNED <b>11/6/1959</b>	
29. BURIAL, CREMATION, REMOVAL (Specify) <b>11-5-9</b>		30. NAME OF CEMETERY OR CREMATORY <b>Croome</b>	
31. LOCATION (City, town, or county) (State) <b>Pr. Geo. Co., Md.</b>		32. FUNERAL DIRECTOR'S SIGNATURE <b>W. E. Scully</b>	
33. ADDRESS <b>1125 Scully St. N. W. - Ky.</b>		34. REC'D BY REGISTRAR <b>NOV 17 '59</b>	
35. REGISTRAR'S SIGNATURE <b>W. E. Scully</b>		36. REGISTRAR'S SIGNATURE <b>W. E. Scully</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12879

CERTIFICATE OF DEATH

12865

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>27 Min</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Prince George</b> b. COUNTY <b>State, Maryland</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Chapel Oaks</b> d. STREET ADDRESS <b>5208 Nye St. N.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Lucy Mary Fields</b>		4. DATE OF DEATH Month Day Year <b>Nov. 2 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 25, 1906</b>
9. AGE (In years last birthday) <b>52 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	11. BIRTHPLACE (State or foreign country) <b>Leonardtwn, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Henry Hayden</b>	
14. MOTHER'S MAIDEN NAME <b>Sophie Holley</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> No	
16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT Address <b>Mr. Roland Fields 5208 Nye St., N. E.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> 447X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive cardiovascular renal disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>yes</b>
21. I certify that I attended the deceased from <b>Nov. 14</b> , 19 <b>59</b> to <b>Nov. 2</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Nov. 2</b> , 19 <b>59</b> , and that death occurred at <b>6:57 P.</b> M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>Tia Bergeron</b> M.D. <b>4314 Jett St. Hyattsville</b> PHYSICIAN'S NAME (Type) <b>Mary Canal</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-6-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>	22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. R. ...</b> ADDRESS <b>Washington D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 9 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. ...</b>

8251-08.112

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **12866**

**12931**

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Dist. of Col.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lewisdale</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6622 23rd Avenue</b>				d. STREET ADDRESS <b>2517 Mozart Place</b>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Francis</b> Last <b>Fitzgerald</b>				4. DATE OF DEATH Month <b>November</b> Day <b>23</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-8-06</b>	9. AGE (In years last birthday) <b>53 yrs.</b>	IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lawyer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. of Jus.</b>		11. BIRTHPLACE (State or foreign country) <b>Connecticut</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William J. Fitzgerald</b>				14. MOTHER'S MAIDEN NAME <b>Mary A. McGrath</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-54-5906</b>		17. INFORMANT Address <b>Douglas A. Clark; Warner Bldg. D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>434.1</b> IMMEDIATE CAUSE (a) <b>Pulmonary and cerebral edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute congestive heart failure</b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b></b> a. m. <b></b> p. m. <b>19</b>	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John T. Maloney</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>November 23, 1959</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/25/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St John's Cemetery</b>		22d. LOCATION (City, town, or county) <b>Norwalk Connecticut</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 25 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

2

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for burial, cremation, or removal.



## CERTIFICATE OF DEATH

Reg. Dist. No.

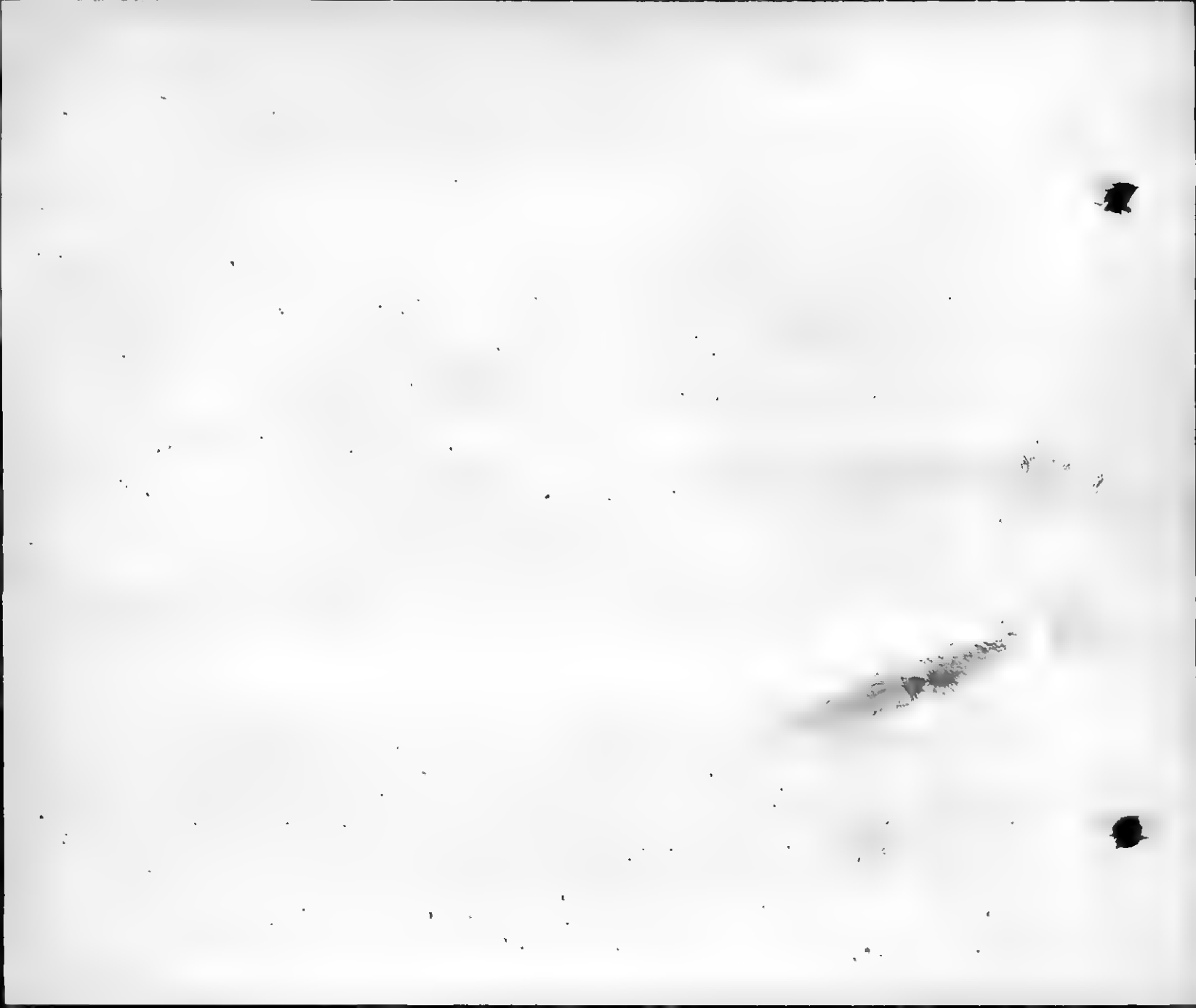
12867

12932

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>W. Hyattsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>W. Hyattsville, Md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <i>3405 Toledo Terrace</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>FRANK FRIEDSON</i>		4. DATE OF DEATH Month Day Year <i>Nov 25 1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 25 1893</i>
9. AGE (In years last birthday) <i>65 yrs</i>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Rug</i>	
11. BIRTHPLACE (State or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Elihanon Friedson</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Diamondson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>MARTIN FRANK - 4311-H ST SE. Wash. D.C.</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Coronary Thrombosis Coronary Atherosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years several years.</i>		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		19b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 1951</i> to <i>Nov 14 1959</i> that I last saw the deceased alive on <i>Nov 14 1959</i> and that death occurred <i>Nov 25 1959</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>3055 16th St. N.W. Nov 25 1959</i> <i>WASHINGTON, D.C.</i>			
ACTUAL SIGNATURE <i>Irwin H. Hager</i>		M.D.	
PHYSICIAN'S NAME (Type) <i>IRWIN H. HAGER</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/27/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>King David Mem Garden</i>		22d. LOCATION (City, town, or county) (State) <i>Falls Church Va.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. Danzansky &amp; Sons</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 30 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>William L. Kiser</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filled with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12933

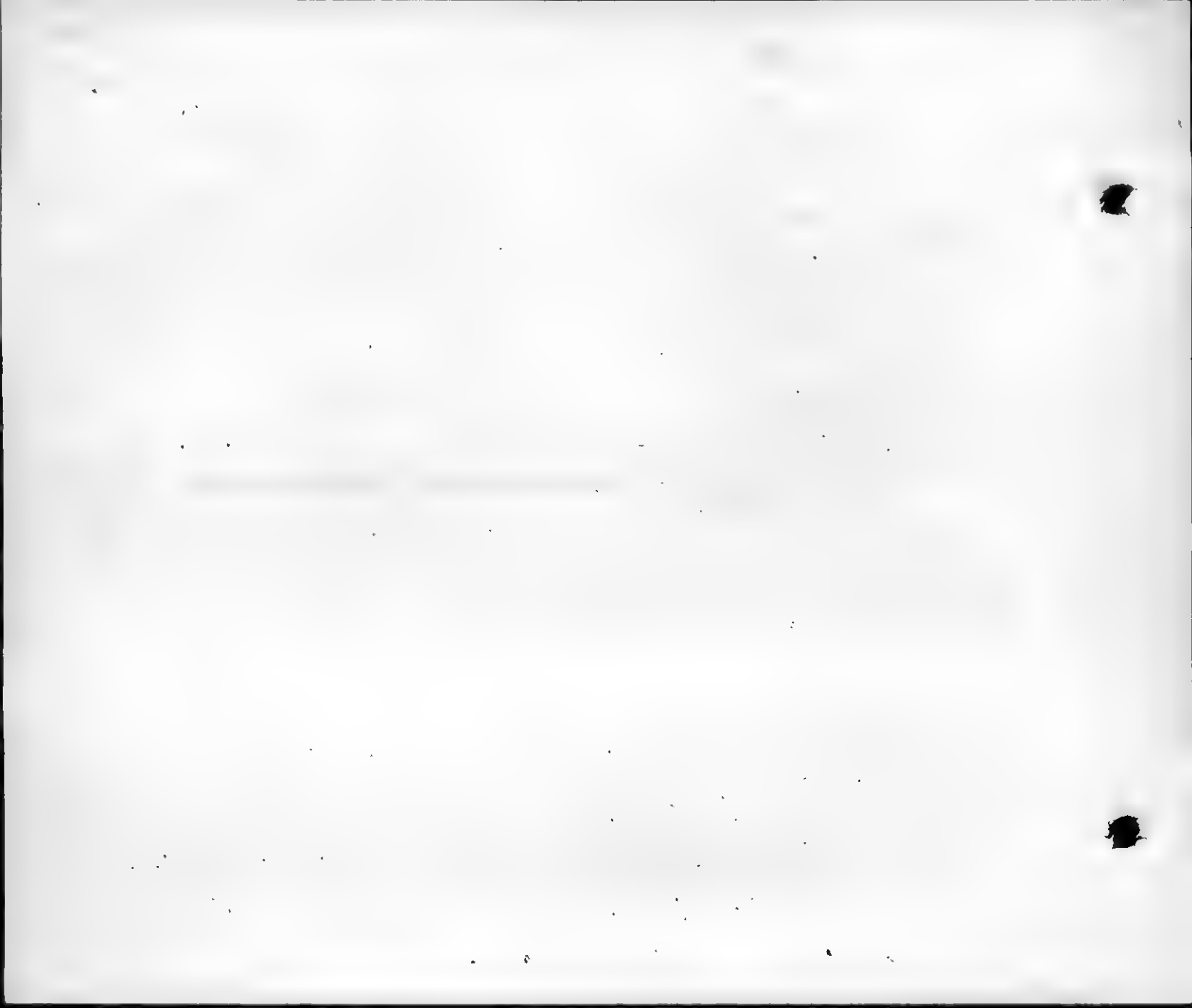
## CERTIFICATE OF DEATH

Reg. Dist. No.

12868

<b>1. PLACE OF DEATH</b> a. COUNTY <b>PRINCE GEORGES</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>VIRGINIA</b> <span style="float: right;">b. COUNTY <b>FAIRFAX</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMP SPRINGS</b>		c. LENGTH OF STAY IN 1b <b>14 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ALEXANDRIA</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSPITAL ANDREWS</b>				d. STREET ADDRESS <b>8 FAIRFAX AVENUE</b>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>ADLAI</b> <span style="float: right;">First</span> <b>H</b> <span style="float: right;">Middle</span> <b>GILKESON</b> <span style="float: right;">Last</span>				<b>4. DATE OF DEATH</b> <b>NOVEMBER</b> <span style="float: right;">Month</span> <b>2</b> <span style="float: right;">Day</span> <b>19 59</b> <span style="float: right;">Year</span>			
<b>5. SEX</b> <b>MALE</b>		<b>6. COLOR OR RACE</b> <b>CAU</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>25 JAN 1893</b>		<b>9. AGE</b> (In years last birthday) <b>66</b> <span style="float: right;">yr.</span>		<b>10. IF UNDER 1 YEAR</b> <span style="float: right;">Months</span> <span style="float: right;">Days</span> <span style="float: right;">Hours</span> <span style="float: right;">Min.</span>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>USAF</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>RETIRED USAF</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>PENNSYLVANIA</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>				<b>13. FATHER'S NAME</b> <b>ANDREW GILKESON</b>			
<b>14. MOTHER'S MAIDEN NAME</b> <b>JANE MCNEIL</b>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>YES</b> <span style="float: right;">(If yes, give year or dates of service)</span> <b>1911 TO 1953</b>			
<b>16. SOCIAL SECURITY NO.</b> <b>231-52-7278</b>		<b>INFORMANT</b> <b>WIFE</b>		<b>Address</b> <b>SEE SECTION 2</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)</b> <b>BILATERAL PULMONARY EDEMA AND ATELECTASIS AND IN-FARCTION</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. <b>(b) RIGHT LOWER LOBE LUNG RESECTION FOR CANCER</b> <b>(c)</b>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).</b> <b>CANCER OF LUNG; PREVIOUS HEART ATTACK; METASTATIC CARCINOMA</b>							
<b>19. WAS AUTOPSY PERFORMED?</b> <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that I attended the deceased from</b> <b>19 OCTOBER</b> <b>1959</b> <b>to</b> <b>2 NOVEMBER</b> <b>1959</b> <b>that I last saw the deceased alive on</b> <b>2 NOVEMBER</b> <b>1959</b> <b>and that death occurred at</b> <b>3:15 PM</b> <b>from the causes and on the date stated above.</b> <b>ADDRESS</b> (Street, city or town, state) <b>USAF HOSPITAL ANDREWS</b> <b>DATE SIGNED</b> <b>2 NOV 59</b>							
<b>PHYSICIAN'S SIGNATURE</b> <i>Phillip A. Cox</i> <b>M.D.</b> <b>USAF HOSPITAL ANDREWS</b> <b>2 NOV 59</b>							
<b>PHYSICIAN'S NAME (Type)</b> <b>PHILLIP A COX LT COL USAF MC USAF HOSPITAL ANDREWS, ANDREWS AFB, MARYLAND</b>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>22b. DATE THEREOF</b> <b>NOV. 5, 1959</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>ARLINGTON NATIONAL</b>			
<b>22d. LOCATION (City, town, or county)</b> <b>ARLINGTON VA.</b>		<b>(State)</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Michael Funeral Home</i>		<b>ADDRESS</b> <b>816 H St. NE. N.W. &amp; NE</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>NOV 5 '59</b>			
<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Thomas</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove-scan-bar papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12860

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Dakoma</u> b. COUNTY <u>Pr. Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dakoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dakoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1211 Elson Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>STEVEN</u> Middle <u>REICH</u> Last <u>GILL</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 27, 1959</u>
9. AGE (In years last birthday) <u>—</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>1</u> Days <u>22</u> Hours <u>—</u> Min <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Dakoma Park, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13. FATHER'S NAME <u>Charles R. Gill</u>		14. MOTHER'S MAIDEN NAME <u>Rosa Stuntz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>M. Charles R. Gill</u>		Address <u>1211 Elson Pl. T.B.M.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congenital heart disease</u> <u>754.7</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Truncus arteriosus</u> DUE TO (c) <u>+ IV septal defect</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Life</u> <u>Life</u> <u>Life</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

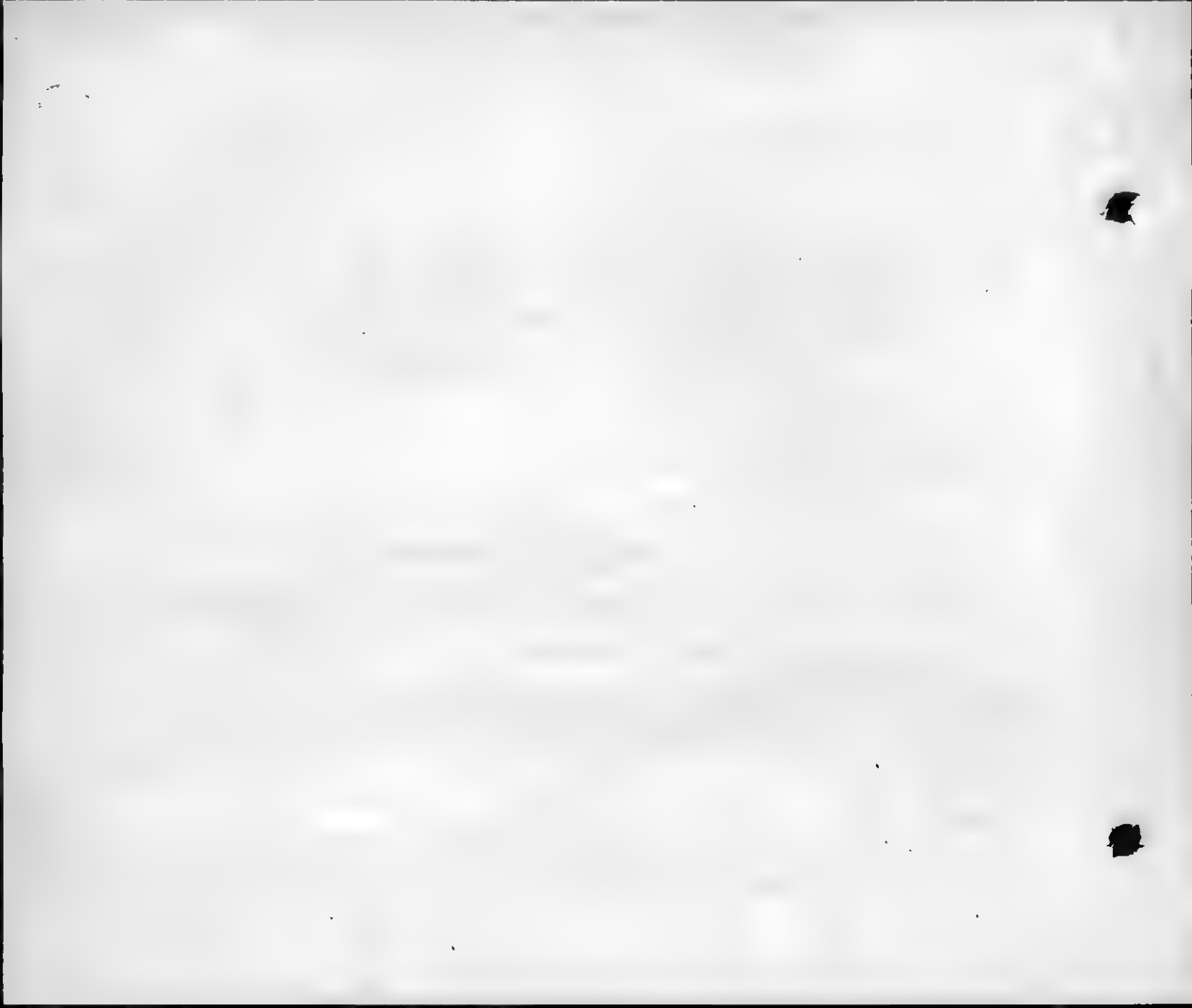
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>29 Sept</u> 1959, to <u>11/19</u> 1959, that I last saw the deceased alive on <u>11/27/59</u> 1959, and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above		ADDRESS (Street, city or town, state) <u>7309 Riggs Rd, W. Hyattsville, Md.</u>	
ACTUAL SIGNATURE <u>Joseph J. McDonald M.D.</u> M.D.		DATE SIGNED <u>11/27/59</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH J. McDONALD M.D.</u>			

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 20, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>		ADDRESS <u>254 Carroll Dr Md DC.</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be relayed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Fil-3252 11-23-59 et

## CERTIFICATE OF DEATH

12870

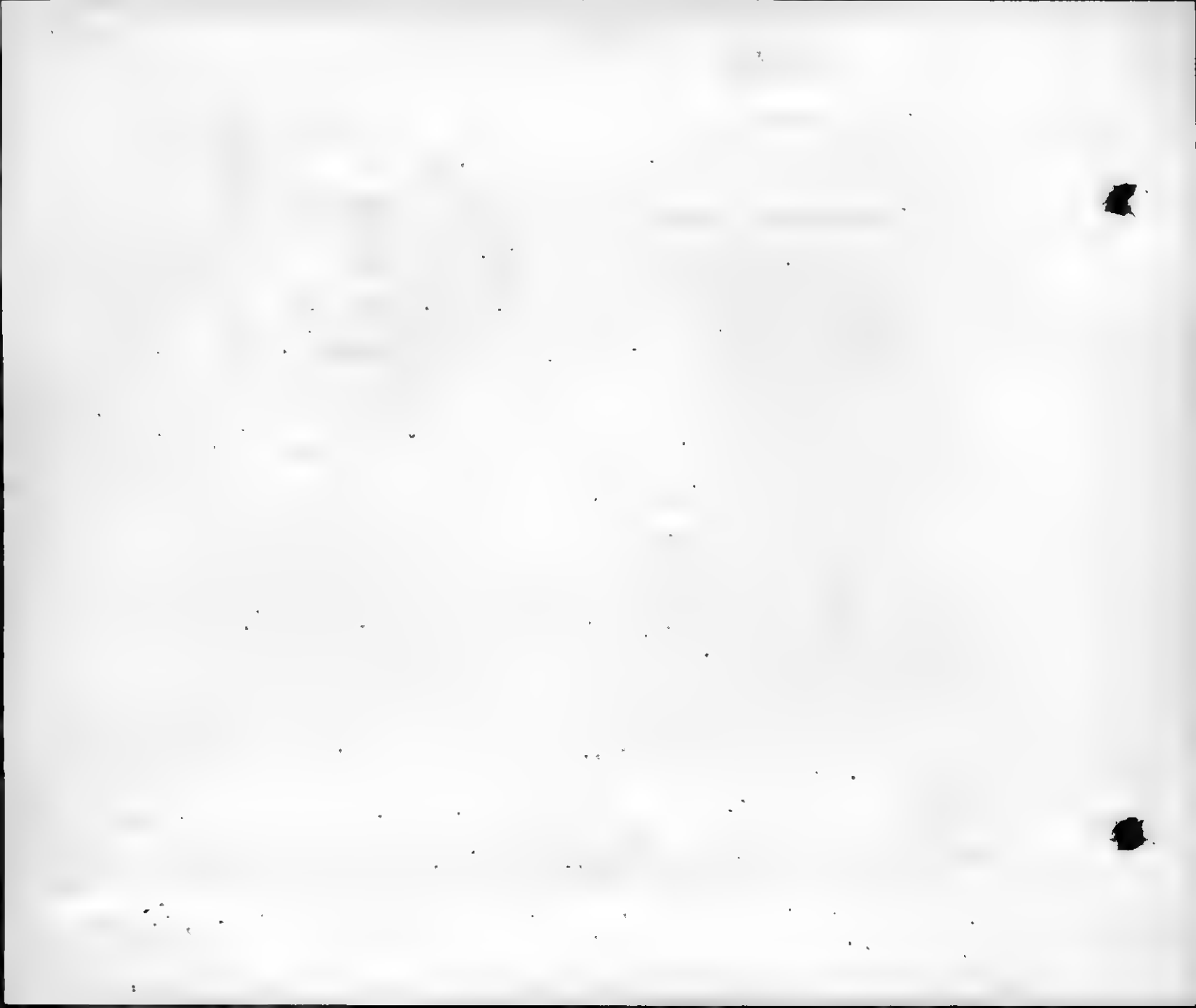
Reg. Dist. No.

12880

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 56 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 3815 37th St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle T Last Gilmore			4. DATE OF DEATH Month Nov Day 14 Year 1959				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 Oct. 1892		9. AGE (In years last birthday) 66 6/67 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Photographer		11. BIRTHPLACE (State or foreign country) Piedmont, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Louise - ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Not		16. SOCIAL SECURITY NO. 216-10-1656		INFORMANT Florence L. Gilmore, Mt. Rainier, Md.		Address 3815-37th St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 418x DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Empyema (b) (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thrombosis of portal vein with infarcts of liver						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from Sept. 9, 1959, to Nov. 14, 1959, that I last saw the deceased alive on Nov. 14, 1959, and that death occurred at 3:55 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE L. C. Gilmore, M.D.				ADDRESS (Street, city or town, state) Colmar Manor, Maryland			
DATE 11/14/59				DATE SIGNED 11/14/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/17/59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town or county) Colmar Manor, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Halley's Funeral Home, Inc.				24a. REC'D BY REGISTRAR DATE NOV 18 '59		24b. REGISTRAR'S SIGNATURE C. S. Finner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12881

## CERTIFICATE OF DEATH

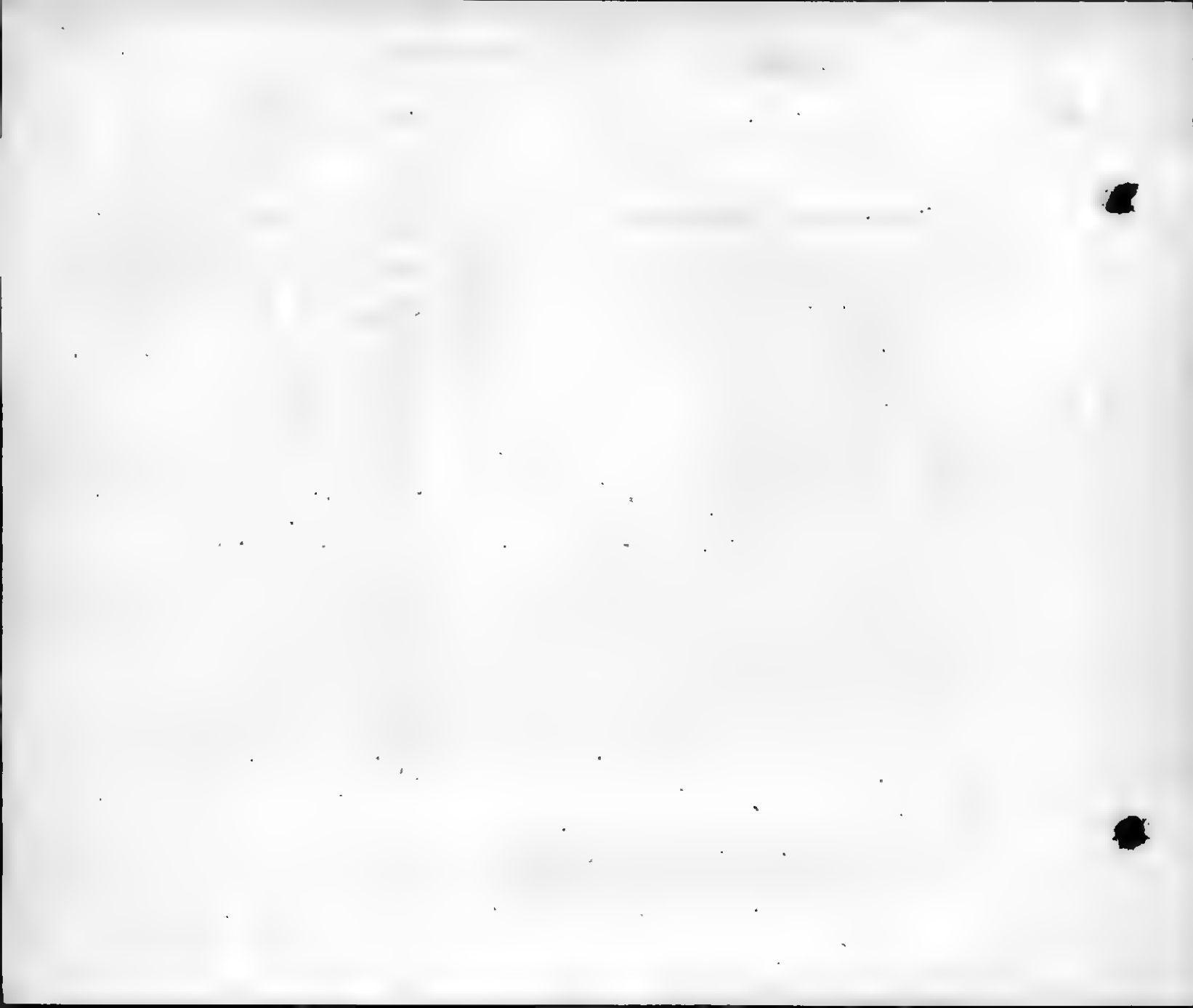
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN TB <b>8 hrs</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clinton</b> d. STREET ADDRESS <b>Clinton</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Earl</b> Middle <b>Goodwin</b> Last <b>Goodwin</b>		4. DATE OF DEATH Month <b>Nov</b> Day <b>15</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Black</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>30 July 1912</b>
9. AGE (In years last birthday) <b>47</b> yrs.		10. IF UNDER 1 YEAR Months <b>17</b> Days <b>15</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Missouri</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Jerry Goodwin</b>		14. MOTHER'S MAIDEN NAME <b>Della Bradshaw</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>Wife, Constance</b>	
17. ADDRESS <b>Same</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442x</b> DUE TO <b>Multiple brain hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive cardiovascular and renal disease</b> DUE TO <b>renal disease</b> (c) <b>renal disease</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 14</b> , 19 <b>59</b> to <b>Nov. 15</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Nov. 14</b> , 19 <b>59</b> , and that death occurred at <b>3,30A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Clinton, Md.</b> DATE SIGNED <b>Nov 15 1959</b>			
ACTUAL SIGNATURE <b>[Signature]</b> M.D.		PHYSICIAN'S NAME (Type) <b>Earl Goodwin</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-19-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Union Bethel Church Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>J.B. Prince George, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Murphy J. Robinson</b>		24a. REC'D BY REGISTRAR <b>DATE NOV 20 '59</b>	
ADDRESS <b>909-6 52 NW</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

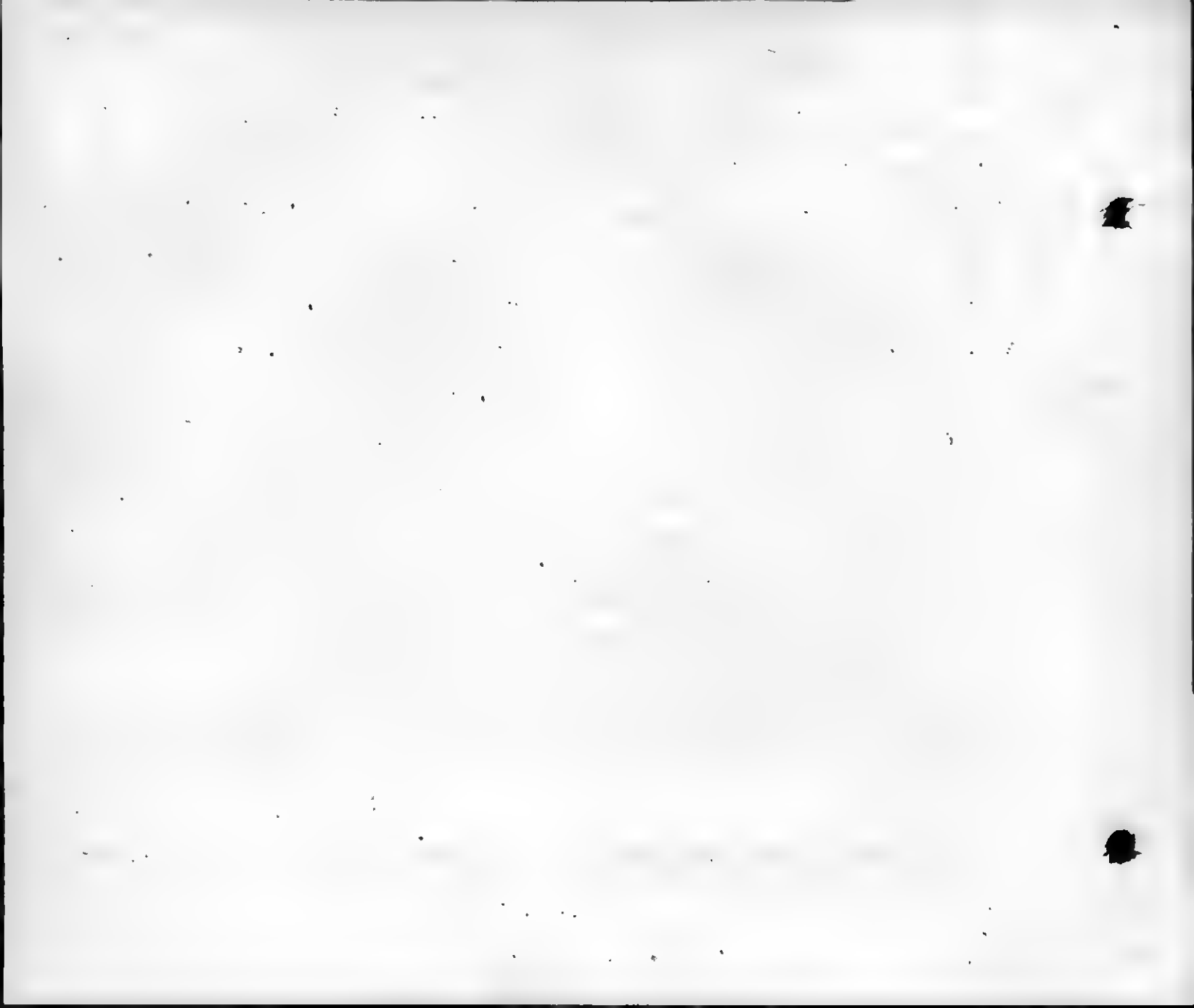
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







12882

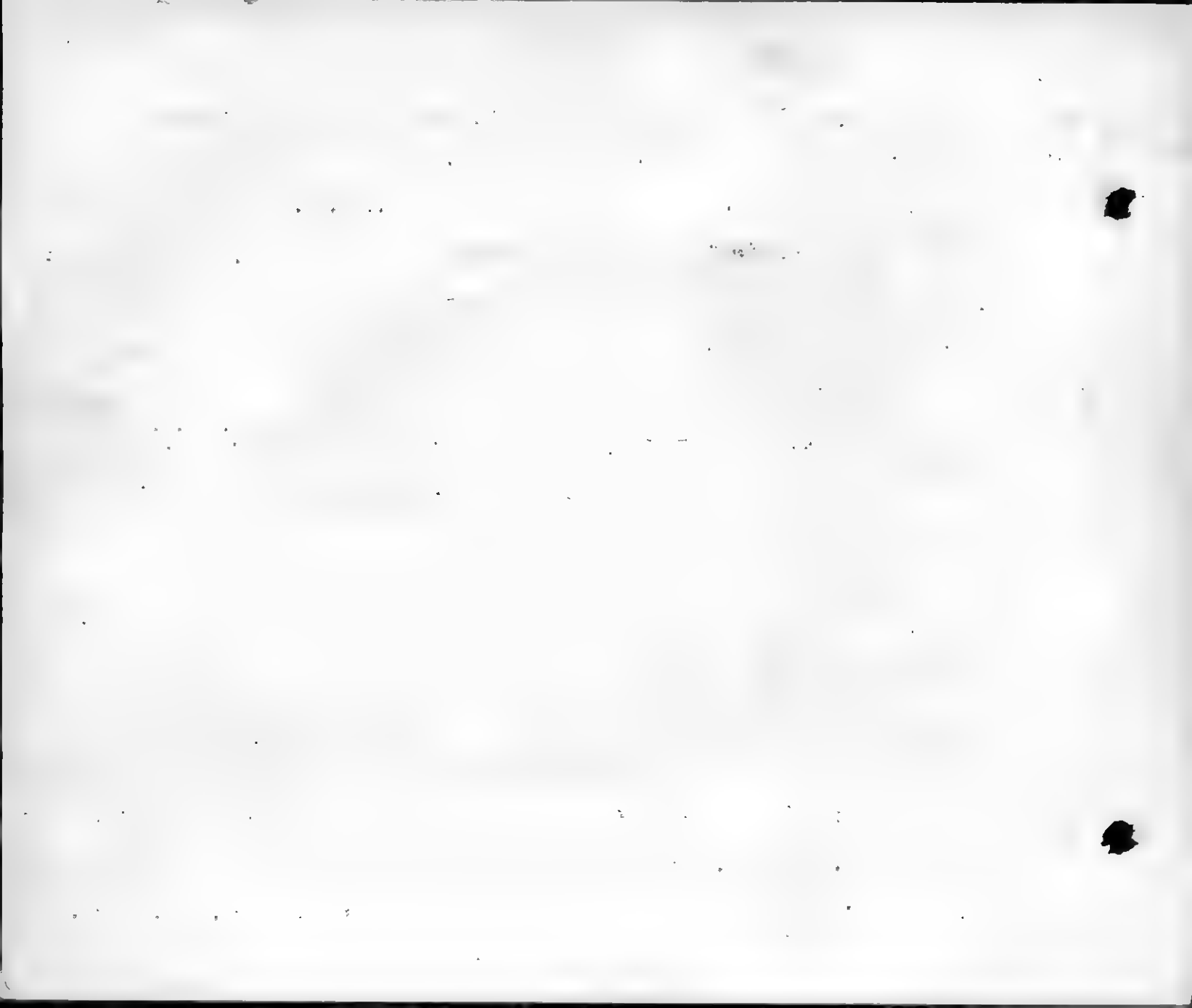
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN TB <b>1 Day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>				d. STREET ADDRESS <b>54 Swann Rd., S. E.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Frederick</b> Middle <b>G</b> Last <b>Gromen</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>19</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-30-24</b>	9. AGE (In years last birthday) <b>35</b> yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laundry and Dry Cleaning</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Michael Gromen</b>				14. MOTHER'S MAIDEN NAME <b>Lena Irre</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>				16. SOCIAL SECURITY NO <b>212-20-0850</b>			
17. INFORMANT <b>Michael Gromen</b>				Address <b>54 Swann Rd., S.E. Suitland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>190.9 Malignant Melanoma</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary edema. Carcinomatosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <b>June</b> , 1955, to <b>Nov 19</b> , 1959, that I last saw the deceased alive on <b>Nov 19</b> , 1959, and that death occurred at <b>9:15 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Donald W. Mitchell</b>				ADDRESS (Street, city or town, state) <b>1746 K St NW</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Donald W. Mitchell</b>				DATE SIGNED <b>20-10-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>11-23-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	
				22d. LOCATION (City, town, or county) <b>Suitland Pr. Geo.</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Summers Bros</b>				ADDRESS <b>1661 Good Hope Rd</b>		24a. REC'D BY REGISTRAR <b>DATE NOV 23 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12935

## CERTIFICATE OF DEATH

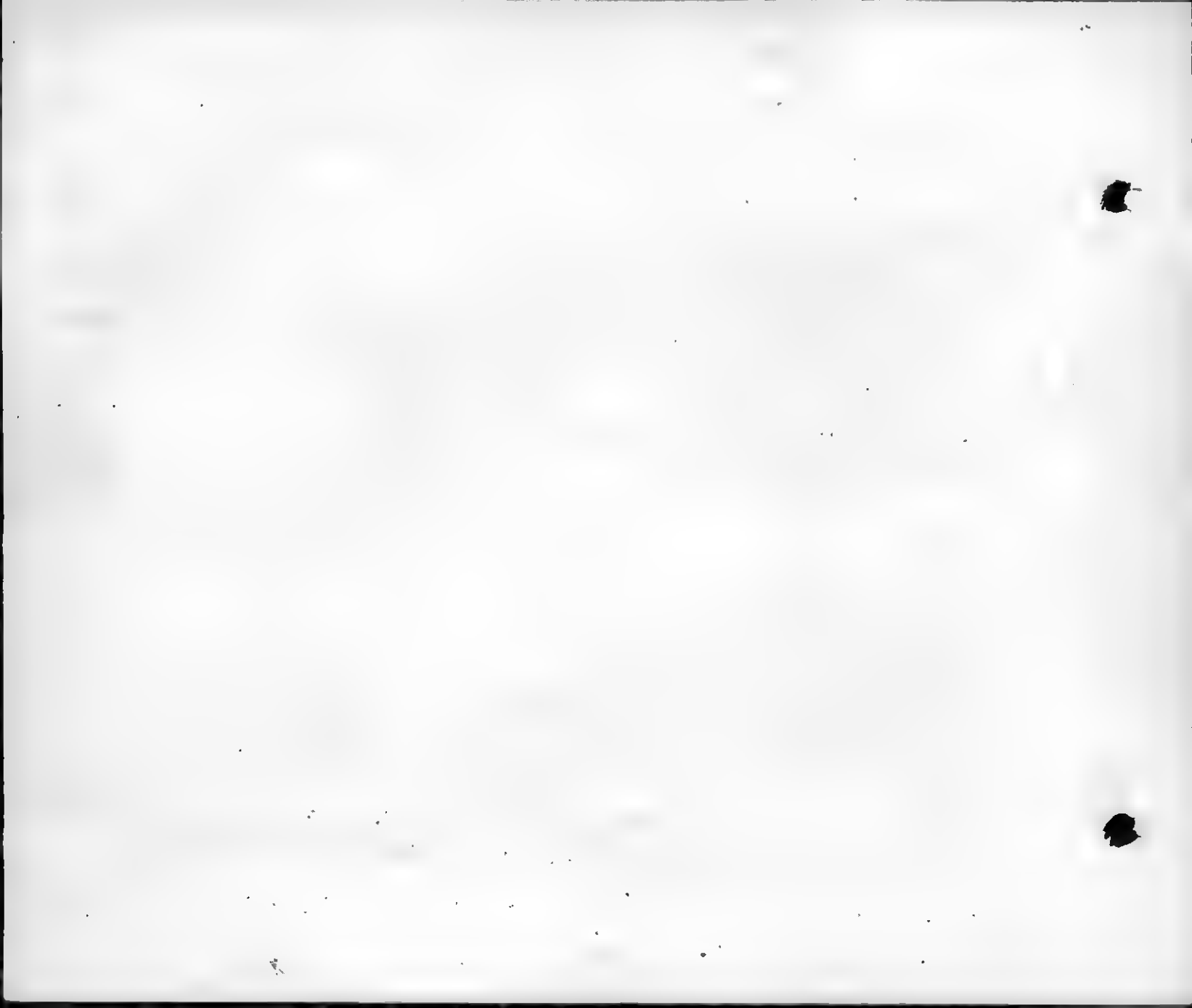
12874

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS		c. LENGTH OF STAY IN 16 3 HRS 20 MINS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LOTHIAN			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS				d. STREET ADDRESS CRANDELL ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MANUEL Middle J Last GROPPER				4. DATE OF DEATH Month NOVEMBER Day 1 Year 19 59			
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 DEC 1895	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GUARD		10b. KIND OF BUSINESS OR INDUSTRY SMITHONIAN INSTITUTE		11. BIRTHPLACE (State or foreign country) NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES 1920 TO 1946		16. SOCIAL SECURITY NO 217-28-8573		INFORMANT DAUGHTER DEBORAH E CLEMENTS		Address 417 50TH AVENUE CAPITOL HEIGHTS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4. . . . . DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 12 HOURS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 1 NOVEMBER, 1959, to 1 NOVEMBER, 1959, that I last saw the deceased alive on 1 NOVEMBER, 1959, and that death occurred at 11:10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Reginald P McManus</i>		M.D. USAF HOSPITAL ANDREWS		DATE SIGNED 1 NOV 59		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type) REGINALD P MC MANUS CAPT USAF MC USAF HOSPITAL ANDREWS, ANDREWS AFB, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 11-5-59		22c. NAME OF CEMETERY OR CREMATORY Arlington Natl.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers & Co. Inc. Washington, D.C.				24a. REC'D BY REGISTRAR DATE NOV 4 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, TO FUNERAL DIRECTOR: This certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

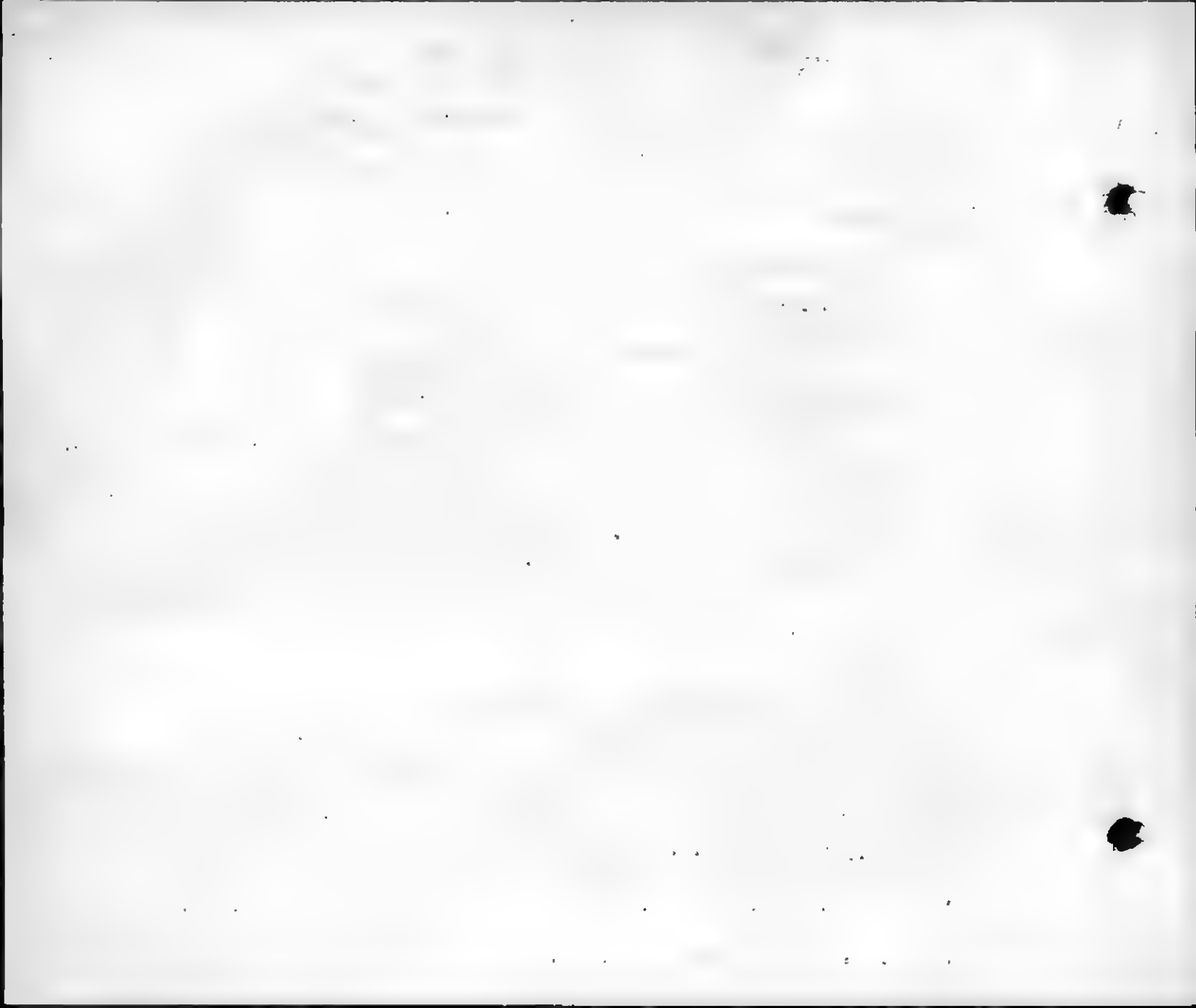
## 12883

### CERTIFICATE OF DEATH

12875

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>University Park</b> d. STREET ADDRESS <b>4000 College Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Elsie C Hammersmith</b>				4. DATE OF DEATH Month Day Year <b>Nov 19 1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 14 1900</b>	
9. AGE (In years last birthday) yrs. <b>59</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Registered Nurse</b>		11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John Keller</b>				14. MOTHER'S MAIDEN NAME <b>Anna Kochis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		INFORMANT Address <b>Mrs H J Isabell University Park, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrest</b> <b>4x0.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>atherosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Ca of metastases to liver and lungs</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 min</b> <b>14</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 14, 1959</b> , to <b>Nov. 19, 1959</b> , that I last saw the deceased alive on <b>Nov 19</b> , 19 <b>59</b> , and that death occurred at <b>1:40 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Til Bergman</b> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <b>4514 College St</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Til Bergman, M.D.</b>				<b>Thyosthalla Mary Carol</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/23/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St Peter &amp; Paul Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 23 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kram</b>			



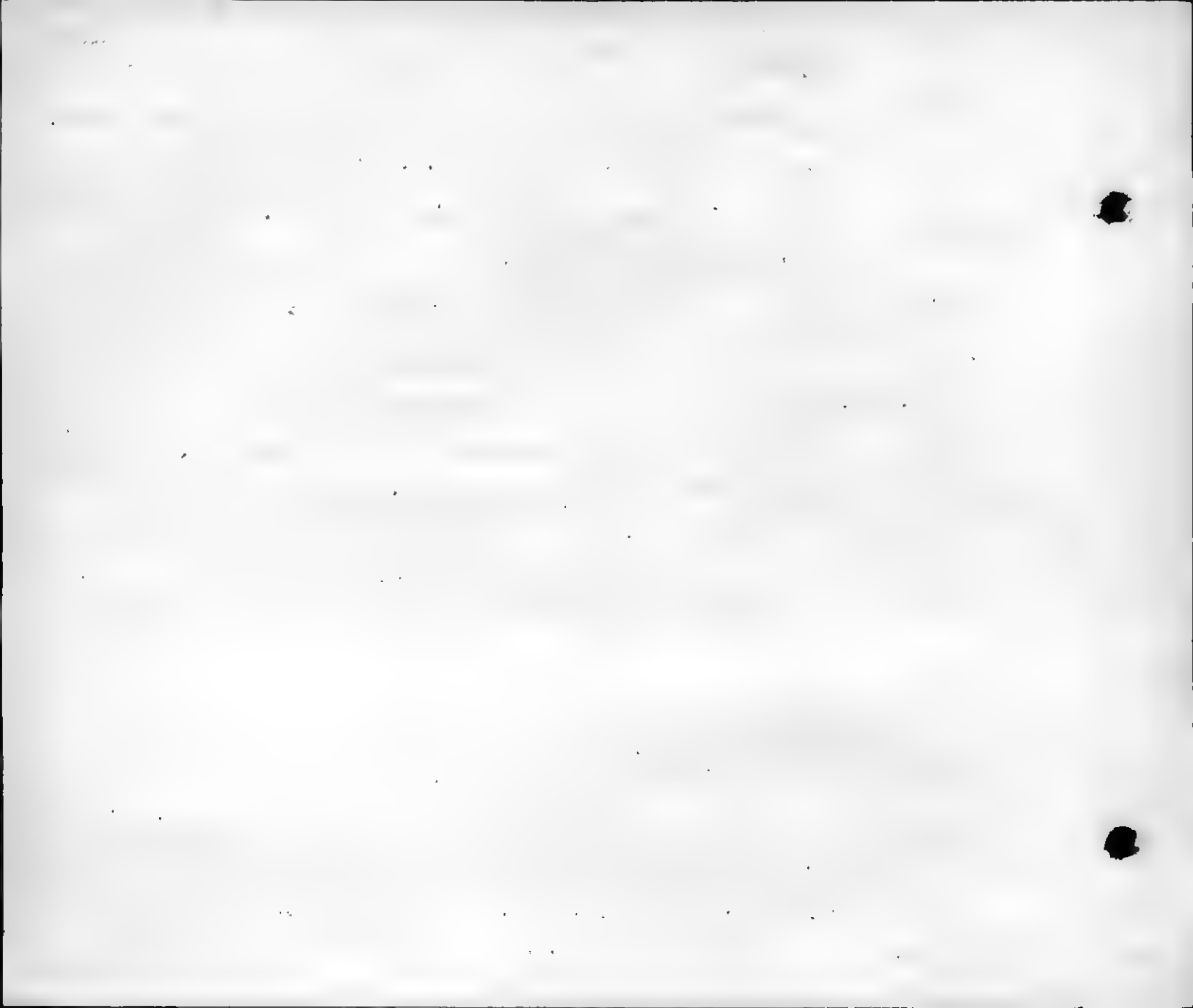
## CERTIFICATE OF DEATH

Reg. Dist. No.

12876

12884

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>6 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>16 Mt. Rainier</b>	
		d. STREET ADDRESS <b>4213 Eastern Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>Harber</b> Last <b>Harber</b>		4. DATE OF DEATH Month <b>Nov</b> Day <b>17</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4 July 1880</b>
9. AGE (In years last birthday) <b>79</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>3</b> Days <b>2</b> Hours <b>4</b> Min. <b>2</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Austria</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry J. Hartman</b>		14. MOTHER'S MAIDEN NAME <b>Hudie Graulich</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>INFORMANT</b> Address <b>Mt. Rainier</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>260X</b> DUE TO <b>Diabetic Mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Myocardial Infarction</b> (b) <b>10 days</b> (c) <b>3 days</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Congestive Heart Failure</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 14, 1959</b> to <b>Nov 17, 1959</b> that I last saw the deceased alive on <b>Nov 16, 1959</b> , and that death occurred at <b>1:50 A.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Benjamin S. Miller M.D.</b>		ADDRESS (Street, city or town, state) <b>3824-34 Mt. Rainier</b>	
PHYSICIAN'S NAME (Type) <b>BENJAMIN S MILLER</b>		DATE SIGNED <b>11/17/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 18, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hebron Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Long Island, New York</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Danzansky &amp; Sons-3501 14th Street, N.W.</b>		24a. REC'D BY REGISTRAR <b>NOV 19 59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



12936

CERTIFICATE OF DEATH

12877

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Heights		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Heights	
d. NAME OF HOSPITAL (If not in hospital, give street address) 912-64th Ave. Cedar Heights		d. STREET ADDRESS 912-64th Ave.	
3. NAME OF DECEASED (Type or print) Wilbur Benjamin Harris		4. DATE OF DEATH Nov. 6 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 30, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Landscaper		10b. KIND OF BUSINESS OR INDUSTRY Construction	9. AGE (In years last birthday) 66 yrs
11. BIRTHPLACE (State or foreign country) S. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 225-20958	
17. INFORMANT Madeline Harris		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pneumonia 41X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchial Asthma DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 wk	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-5-1959, to 11-6-1959, that I last saw the deceased alive on 11-6-1959, and that death occurred at 3:50 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John W. Robinson		DATE SIGNED 11-6-59	
PHYSICIAN'S NAME (Type) John W. Robinson, M.D.		ADDRESS (Street, city or town, state) 1001 Eastern Ave. N.E.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 11-10-59	22c. NAME OF CEMETERY OR CREMATORY St. James Ch. Cemetery	22d. LOCATION (City, town, or county) (State) Powhatan Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington Son		24a. REC'D BY REGISTRAR DATE NOV 10 '59	
ADDRESS 467 N. St. W.		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12885

## CERTIFICATE OF DEATH

Reg. Dist. No.

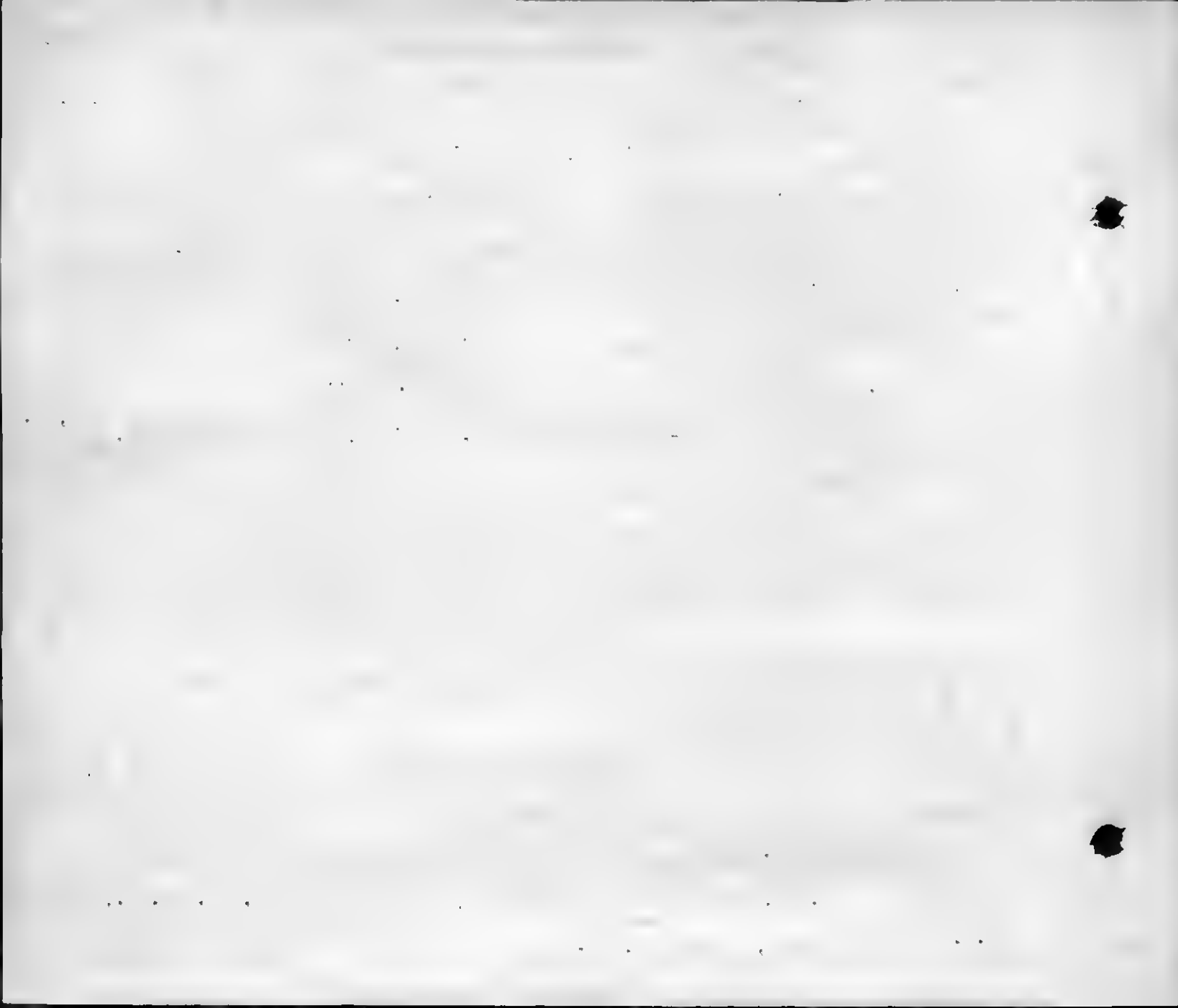
12878

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>				c. LENGTH OF STAY IN 1b <b>5 minutes</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>14 College Park</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eugene Leland Memorial Hospital</b>				d. STREET ADDRESS <b>6903 Dartmouth Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>FLORENCE ANNISE HARRISON</b>				4. DATE OF DEATH Month Day Year <b>November 2nd, 19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 19th, 1889</b>	
9. AGE (In years last birthday) <b>70 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>		11. BIRTHPLACE (State or foreign country) <b>Brandon, Vermont</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George M. Norton</b>				14. MOTHER'S MAIDEN NAME <b>Jennie L. Murray</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-01-4832B</b>		17. INFORMANT <b>James W. Harrison, 6903 Dartmouth Ave.,</b> Address <b>College Park, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO <b>CORONARY SCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Hypertensive Heart Disease</b> (c) <b>12 hrs</b> <b>5 yrs</b> <b>6 yrs</b>						INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>5 yrs</b> <b>6 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1953</b> to <b>Nov 1959</b> , that I last saw the deceased alive on <b>Nov 2, 1959</b> , and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3824-34th Tr Ramon</b> DATE SIGNED <b>11-2-59</b> ACTUAL SIGNATURE <b>Benjamin S. Miller</b> M.D. PHYSICIAN'S NAME (Type) <b>Benjamin S. Miller</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 5th, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Celmar Manor, Pr. Geo. Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Company, Riverdale, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 5 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>	

MEDICAL CERTIFICATION

I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12879

12886

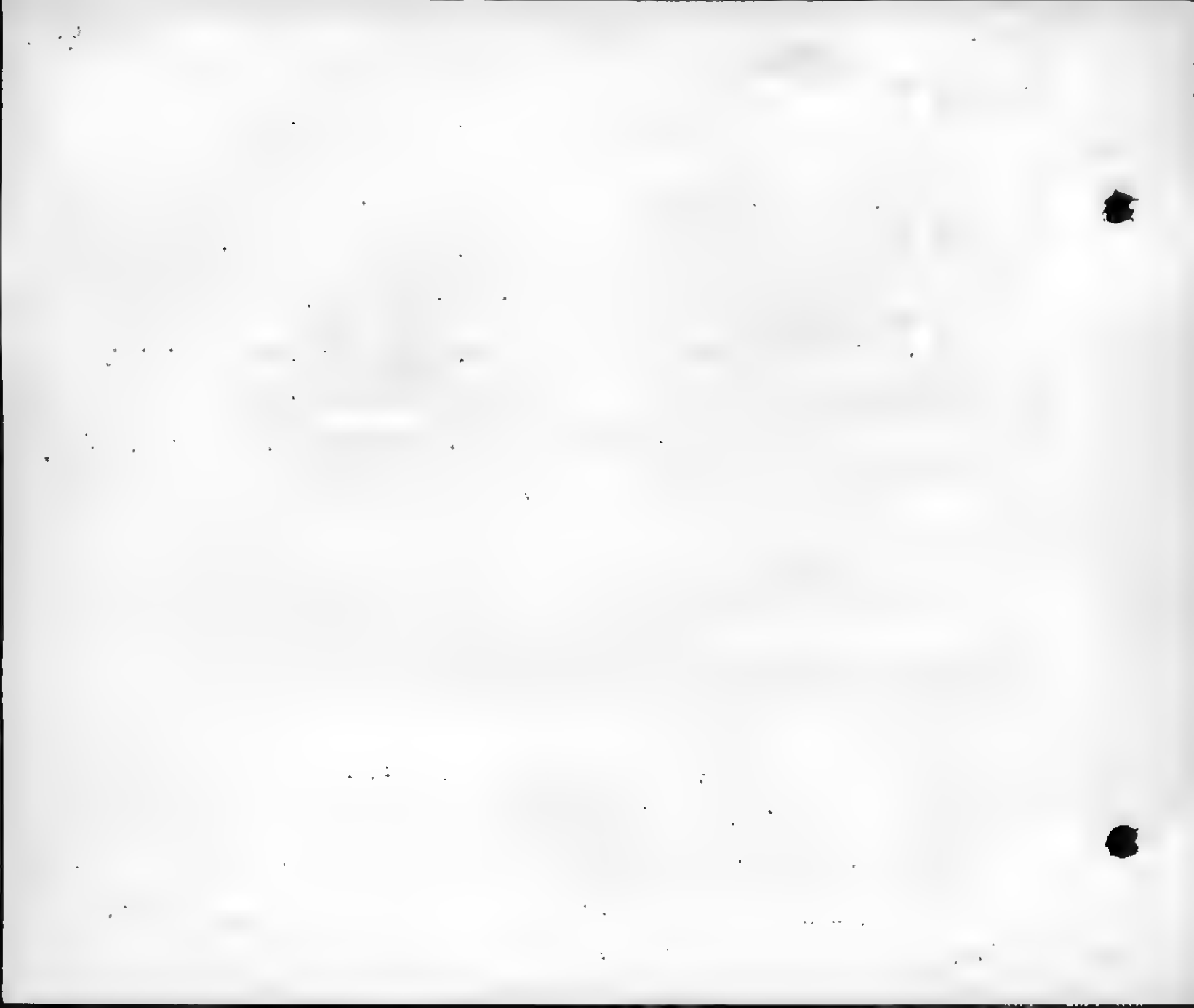
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>11 Hr</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		d. STREET ADDRESS <u>5731 29th Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Paul</u> First <u>L</u> Middle <u>Hathaway</u> Last		4. DATE OF DEATH Month <u>Nov.</u> Day <u>2</u> Year <u>1959</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Jan. 9, 1906</u>		9. AGE (In years last birthday) <u>53</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager of Bakery</u>		11. BIRTHPLACE (State or foreign country) <u>Bennington, Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dana Hathaway</u>		14. MOTHER'S MAIDEN NAME <u>Zura Agnes Startzman</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>511-07-9915</u>		17. INFORMANT <u>Paul L. Hathaway Jr.</u> Address <u>1030-Nolan Lane Chula Vista, Cal.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.1</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION G. VEN IN PART I (a) _____ 19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from _____ 19 _____ to _____ 19 _____, that I last saw the deceased alive on _____ 19 _____, and that death occurred at _____ 10:55 A.M. _____ from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Dr. Fleischer</u>		ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
PHYSICIAN'S NAME (Type) <u>Dr. Fleischer</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-5-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) _____ (State) _____ <u>Colmar Manor Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley Funeral Home</u>		ADDRESS <u>mt. Rainier Md.</u>		DATE <u>NOV 5 '59</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kline</u>		24b. REGISTRAR'S SIGNATURE	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12937

12880

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Latham Hill</u>		c. LENGTH OF STAY IN 1b <u>4 mos</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Latham</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7730 Garrison</u>			d. STREET ADDRESS <u>7730 Garrison</u>		e. IS RES. DONE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Bonnie</u> Middle <u>C.</u> Last <u>Hankins</u>			4. DATE OF DEATH Month <u>11</u> Day <u>1</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-7-59</u>		9. AGE (in years last birthday) yrs <u>23</u> Months <u>3</u> Days <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Ray J. Hankins</u>		14. MOTHER'S MAIDEN NAME <u>Martha White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT <u>Ray J. Hankins, Farmville, Va.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured femur</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John T. Maloney</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11-1-59</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 10, 1959</u>		22c. NAME OF CEMETERY OR CREMATOR <u>Arlington National</u>	
22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 10 '59</u>	
ADDRESS <u>Hyattsville Maryland.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur A. Hume</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

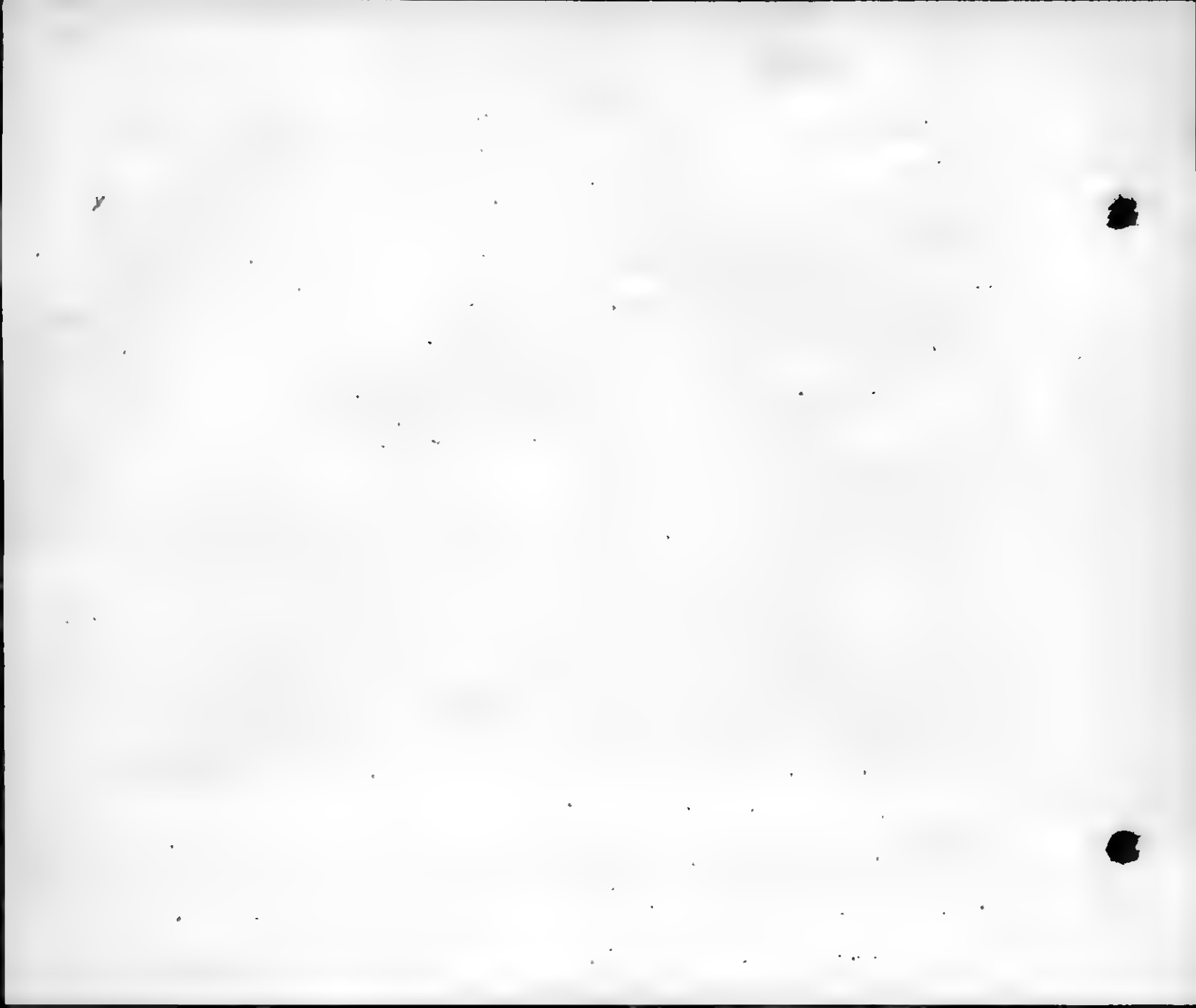
## CERTIFICATE OF DEATH

Reg. Dist. No.

12887

12881

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>12 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Mildred Hawkins</b>		4. DATE OF DEATH Month Day Year <b>Nov. 17 19 59</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-31-13</b>
9. AGE (In years for: birthday) yrs <b>46</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Frank Harper</b>		14. MOTHER'S MAIDEN NAME <b>Harriett Miller</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Harriett Harper Waldorf, Maryland</b>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>subarachnoid hemorrhage</b> <b>452X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Aneurysm Circle of Willis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b> <b>UNKNOWN</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov 5</b> , 19 <b>59</b> , to <b>Nov 17</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Nov. 17</b> , 19 <b>59</b> , and that death occurred at <b>8:20 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Norman D. Comeau</b> M.D.		DATE SIGNED <b>11/17/59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Comeau (Norman)</b>		<b>MT Rainier Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-21-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St Peters</b>	22d. LOCATION (City, town, or county) (State) <b>Waldorf, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, Waldorf, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 23 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles E. Harris</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12882

12888

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b. STATE <u>Prince George's</u> c. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>William F. Henderson</u>		4. DATE OF DEATH Month <u>11</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>A</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Walter Henderson</u> Address <u>4404 Greenbury Road</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>440.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years?</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-8</u> , 19 <u>59</u> , to <u>11-18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11-18</u> , 19 <u>59</u> , and that death occurred at <u>11:23</u> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rowland F. Wickman</u> M.D.		DATE SIGNED <u>4404 Greenbury Road 11-18-59</u>	
PHYSICIAN'S NAME (Type) <u>Rowland F. Wickman</u>		<u>Rowland F. Wickman</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Nov 21, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville Maryland</u>		24a. REC'D BY REGISTRAR <u>NOV 23 '59</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Orlando S. Kline</u>	

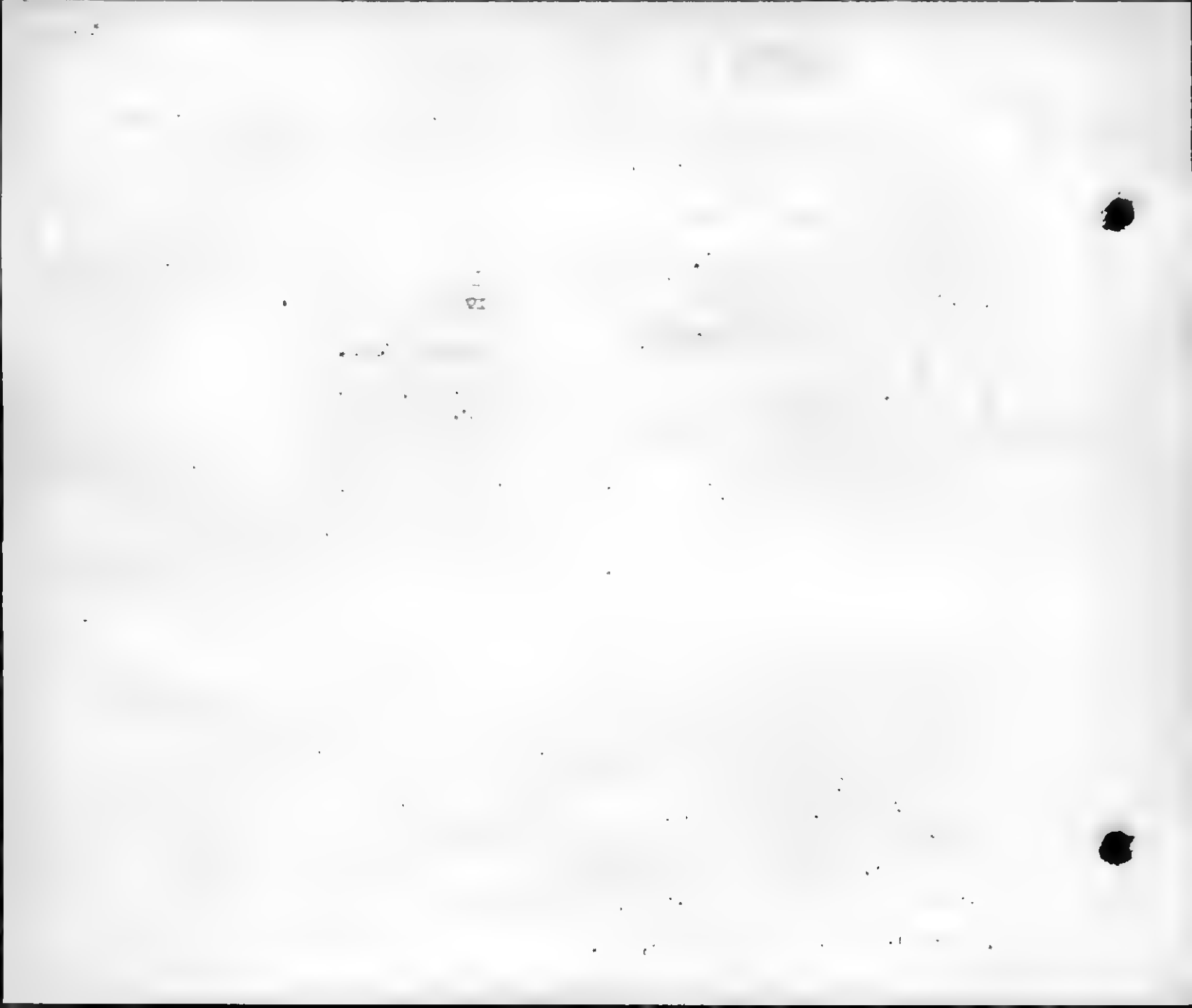


12889

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>1 Hr. 10min</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>14 College Park</b>	
		f. STREET ADDRESS <b>4708 Indian Lane</b>	
3. NAME OF DECEASED (Type or print) First <b>Elaine F.</b> Middle <b>Hickey</b> Last <b></b>		4. DATE OF DEATH Month <b>November</b> Day <b>6</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/14/46</b>
9. AGE (In years last birthday) <b>12 yrs</b>		10. IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	11. IF UNDER 24 HRS Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Student</b>	
11. BIRTHPLACE (State or foreign country) <b>Conn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>Edward D. Hickey</b>		14. MOTHER'S MAIDEN NAME <b>Evelyn T. Kosky</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
INFORMANT <b>D. Hickey</b> Address <b>Edward (Father) Address same as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331x</b> <b>Massive left intra cerebral</b> DUE TO <b>intra tentorial &amp; subarachnoid 2 hrs.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Removal of large</b> DUE TO (c) <b></b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b></b> o. m. <b></b> p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-6-59</b> to <b>11-6-59</b> , that I last saw the deceased alive on <b>November 6, 1959</b> , and that death occurred at <b>9:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr. Etienne</b> M.D.		ADDRESS (Street, city or town, state) <b>4713 - Bryn Mawr Rd College Park Md</b> DATE SIGNED <b>11-6-59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Etienne</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/10/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Gate Of Heaven Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Wheaton Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 10 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>



12890

## CERTIFICATE OF DEATH

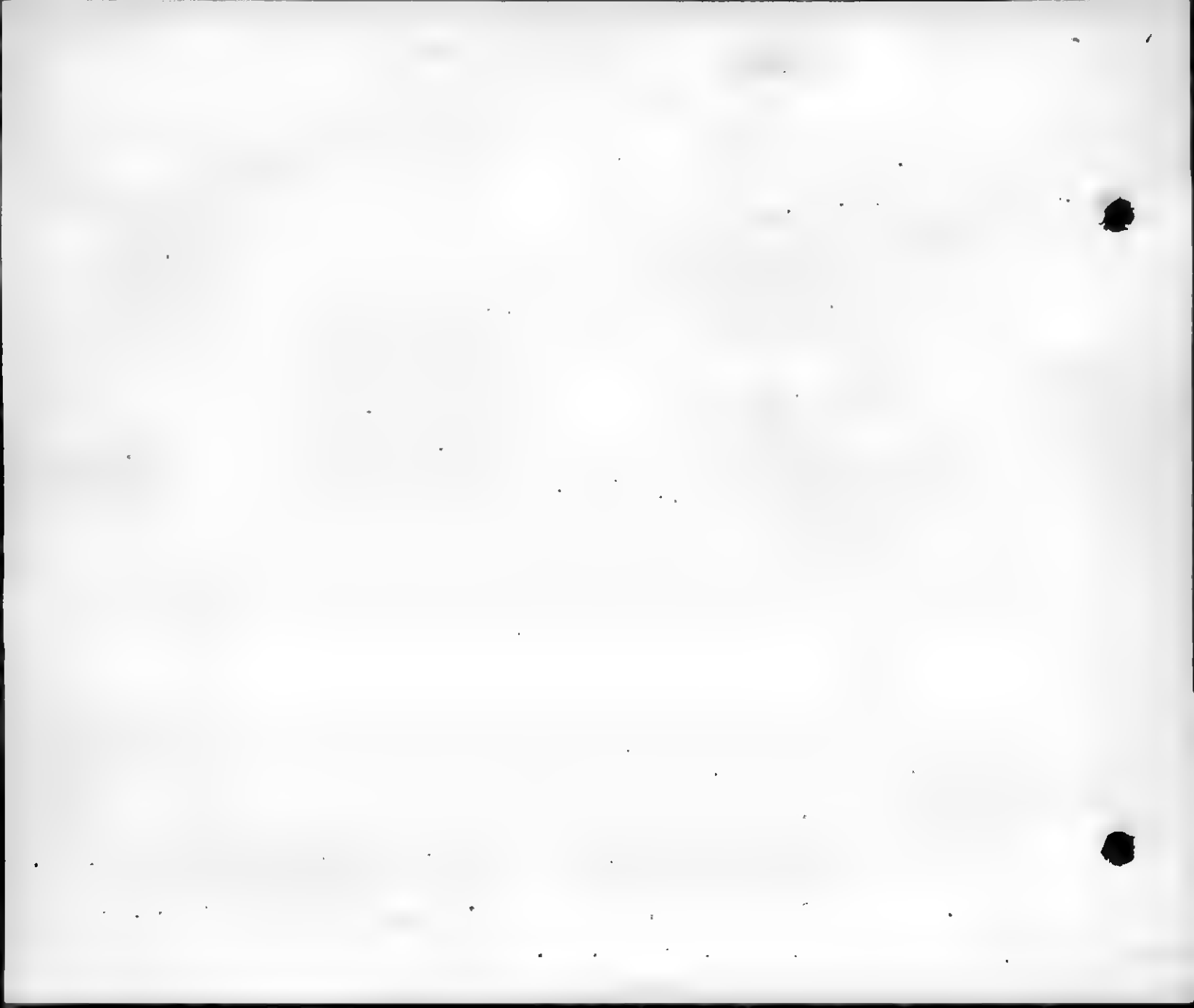
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Upper Marlboro	
		f. STREET ADDRESS /	
		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Clyde D Holmes		4. DATE OF DEATH Month Day Year November 1 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/18/59
9. AGE (In years last birthday) yrs. 14		10. IF UNDER 1 YEAR Months Days Hours Min. 14	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Vincent Holmes		14. MOTHER'S MAIDEN NAME Clara (nee Hamilton)	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Clara- Mother Address same as above.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 764.0 DUE TO <u>bleeding</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>bleeding</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Inter-ventricular septal defect.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 30, 19 59 to Nov 1, 59, that I last saw the deceased alive on November 1, 59, and that death occurred at 10:10 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bertha VanGelderren</u> M.D.		DATE SIGNED <u>11/3/59</u>	
PHYSICIAN'S NAME (Type) Bertha VanGelderren, M. D.		3001 Cheverly Ave., Cheverly, Md.	
22a. BURIAL, CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 11/3/59	22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery	22d. LOCATION (City, town, or county) (State) Upper Marlboro, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.		24a. REC'D BY REGISTRAR DATE NOV 4 '59	
		24b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be released by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2011-46XV6



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

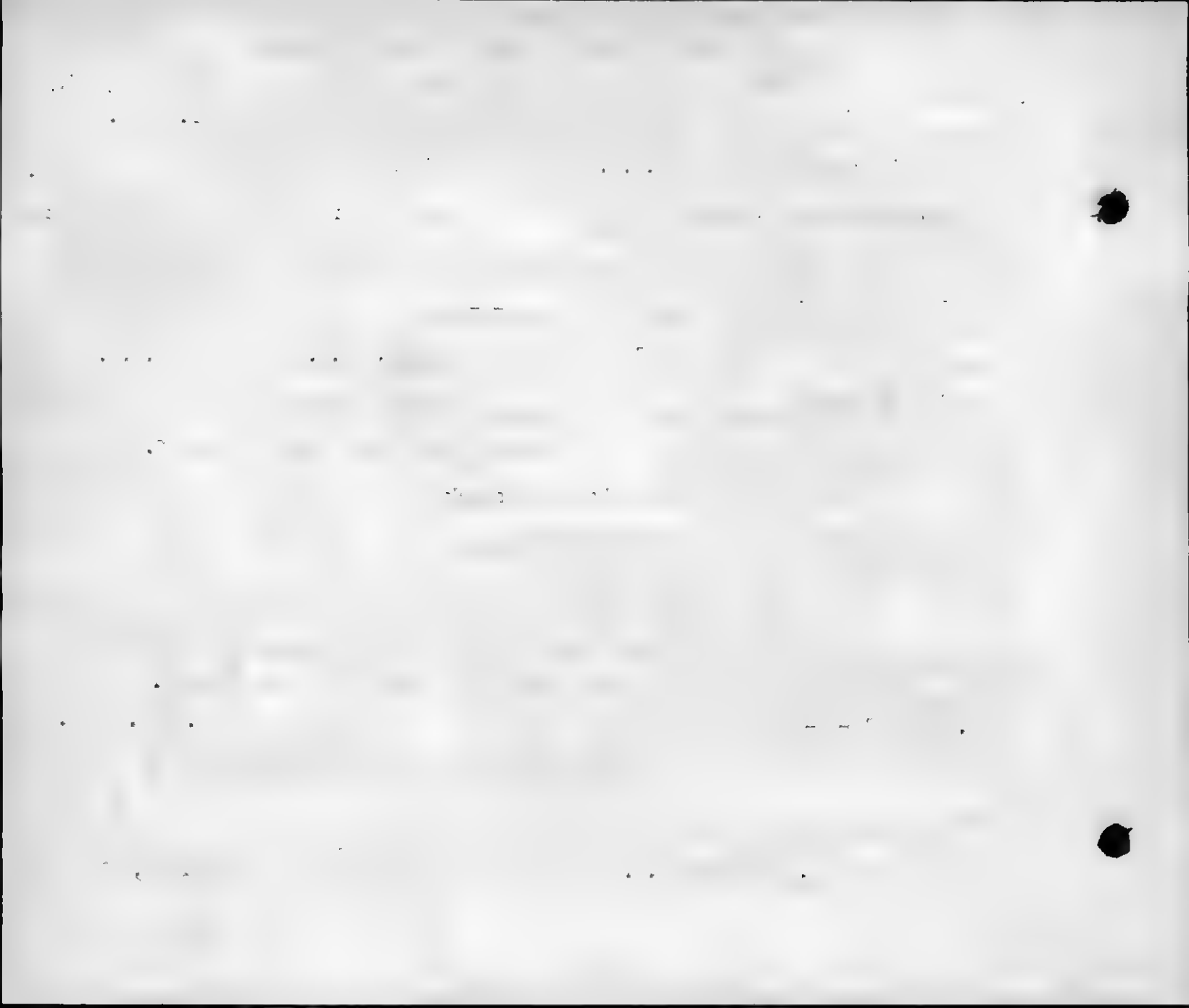
12885

12891

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ieland Memorial Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 Riverdale</u> d. STREET ADDRESS <u>5411 Taylor Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Gregory</u> Middle <u>Horan</u> Last <u>Horan</u>		<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>25</u> Year <u>19 59</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>7-3-53</u>	<b>9. AGE</b> (In years last birthday) <u>6</u> yrs. <b>10. IF UNDER 1 YEAR</b> Months <u>6</u> Days <u>19</u> Hours <u>59</u> Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Student</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>School</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Washington, D.C.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>William Horan</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Helen Blackburn</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>Helen Horan; same address as # 2.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of skull</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input checked="" type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by automobile while walking home from school.</u>	
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>3:00 a. m. 11-25-59</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Highway</u> <b>20f. (City or town)</b> <u>Riverdale</u> <b>(County)</b> <u>Pr. Geo.</u> <b>(State)</b> <u>Md.</u>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
<b>ACTUAL SIGNATURE</b> <u>John T. Maloney</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>EXAMINER'S NAME (Type)</b> <u>John T. Maloney, M.D.</u>		<b>DATE SIGNED</b> <u>November 25, 1959</u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>NOV. 28 1959 BURIAL</u>		<b>22b. DATE THEREOF</b> <u>NOV. 28 1959</u>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>GATE OF HEAVEN CEM.</u>		<b>22d. LOCATION (City, town, or county)</b> <u>WHEATON, MARYLAND</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John T. Maloney</u>		<b>24. REC'D BY REGISTRAR</b> <u>DATE NOV 30 '59</u>	
<b>25. ADDRESS</b> <u>2224-WIS. AVE</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>John T. Maloney</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar for to burial, cremation, or removal.  
 VS. AISM(E)S  
 SM 9/55



12938

## CERTIFICATE OF DEATH

12886

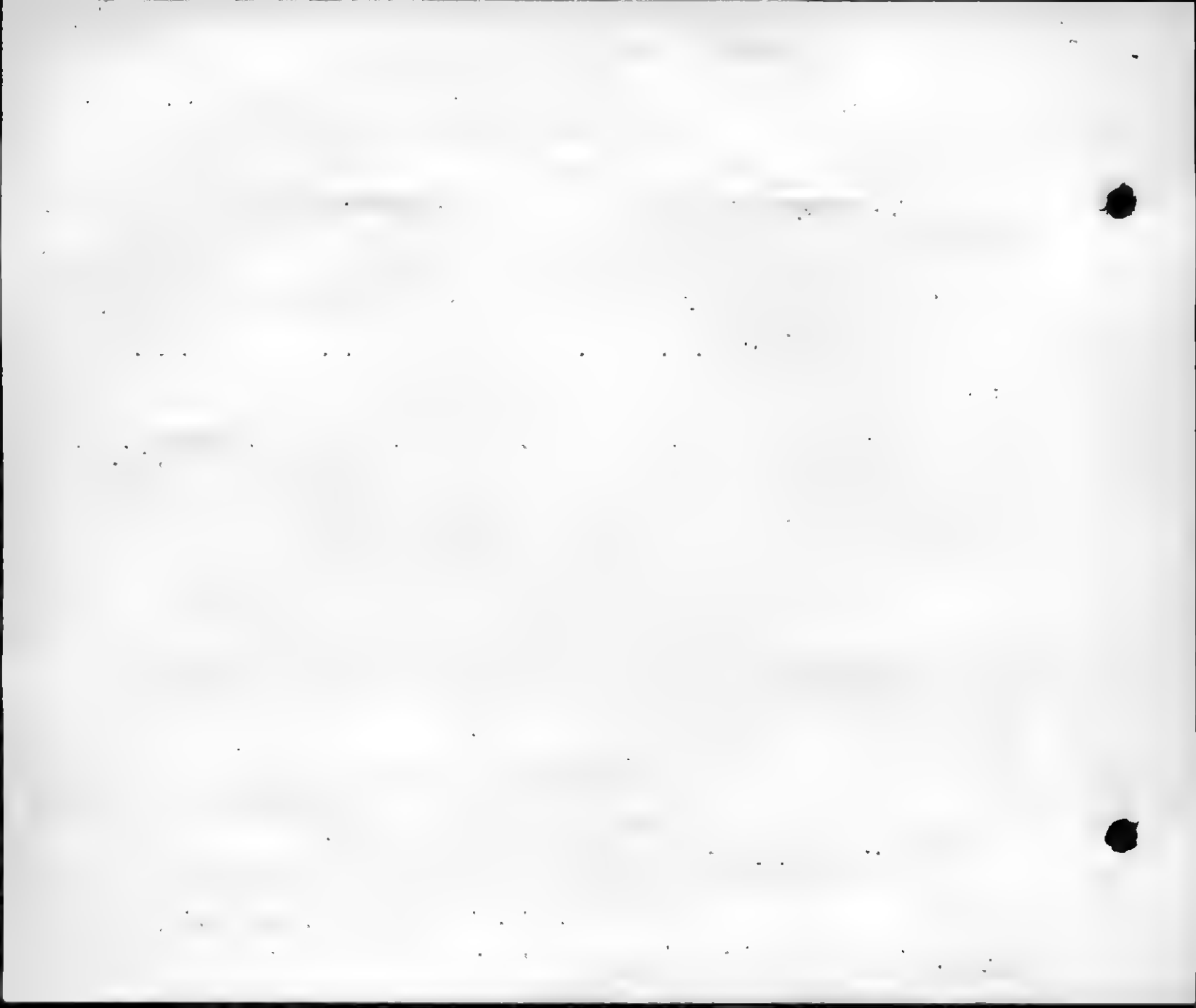
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Langley Park</b>		c. LENGTH OF STAY IN lb <b>2 years</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LANGLEY PARK</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1302 Merimac Drive</b>		d. STREET ADDRESS <b>1302 Merimac Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SARAH</b> Middle <b>ROSALIE</b> Last <b>HOWARD</b>		4. DATE OF DEATH Month <b>11</b> Day <b>8</b> Year <b>1959</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 9, 1870</b>	9. AGE (In years lost birthday) <b>89 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Gov't.</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>DeWitt Teeple</b>		14. MOTHER'S MAIDEN NAME <b>Mary Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>none</b>		INFORMANT Address <b>Mrs. Pearl Handiboe, 1302 Merimac Drive Silver Spring, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0 Renal Insufficiency (Nephria)</b> DUE TO (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>Senility</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>May</b> , 19 <b>59</b> to <b>Nov</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Nov 7</b> , 19 <b>59</b> , and that death occurred at <b>8:30 P</b> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Bernard A Fitzgerald</b>		ADDRESS (Street, city or town, state) <b>217 University Blvd E.</b>		DATE SIGNED <b>11-8-59</b>	
PHYSICIAN'S NAME (Type) <b>BERNARD A. FITZGERALD</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/12/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l. Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Arlington, Virginia</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>WALTER E. PUMPHREY, INC.</b>		ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>Nov 10 1959</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12887

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> <span style="font-size: 1.2em;">Prince Georges</span> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) <b>a. STATE</b> <span style="font-size: 1.2em;">Maryland</span> <b>b. COUNTY</b> <span style="font-size: 1.2em;">Pr. Geo.</span>			
<b>b. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Cheverly</span>		<b>c. LENGTH OF STAY IN 1b</b> <span style="font-size: 1.2em;">D.O.A.</span>		<b>c. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Mitchellville</span>		<b>d. STREET ADDRESS</b> <span style="font-size: 1.2em;">Woodmore Road</span>	
<b>d. NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital, give street address) <span style="font-size: 1.2em;">Prince Georges General Hospital</span>				<b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <span style="font-size: 1.2em;">Pearl</span> Middle <span style="font-size: 1.2em;">Geneva</span> Last <span style="font-size: 1.2em;">Hutchinson</span>				<b>4. DATE OF DEATH</b> Month <span style="font-size: 1.2em;">November</span> Day <span style="font-size: 1.2em;">19</span> Year <span style="font-size: 1.2em;">19 59</span>			
<b>5. SEX</b> <span style="font-size: 1.2em;">Female</span>		<b>6. COLOR OR RACE</b> <span style="font-size: 1.2em;">White</span>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">Oct. 10, 1912</span>	
<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">47</span> yrs.		<b>IF UNDER 1 YEAR</b> Months <span style="font-size: 1.2em;"> </span> Days <span style="font-size: 1.2em;"> </span>		<b>IF UNDER 24 HRS.</b> Hours <span style="font-size: 1.2em;"> </span> Min. <span style="font-size: 1.2em;"> </span>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Tenent</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.A.</span>		<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Charles Hutchinson</span>	
<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Mary Windsor</span>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) No		<b>16. SOCIAL SECURITY NO.</b> (If yes, give war or dates of service)		<b>17. INFORMANT</b> Address <span style="font-size: 1.2em;">Emory R. Hutchinson; same address as # 2.</span>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <span style="font-size: 1.2em;">Acute congestive heart failure</span>  <span style="font-size: 1.5em;">434.2</span> DUE TO          Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <span style="font-size: 1.2em;">Cardiac asthma</span>          DUE TO (c) <span style="font-size: 1.2em;"> </span> </div> <div style="width: 15%; text-align: center;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <span style="font-size: 1.2em;"> </span> </div> </div>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <span style="font-size: 1.2em;"> </span>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>		<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>					
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <span style="font-size: 1.2em;"> </span>		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <span style="font-size: 1.2em;"> </span> a. m. <span style="font-size: 1.2em;"> </span> p. m. <span style="font-size: 1.2em;">19</span>					
<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <span style="font-size: 1.2em;"> </span>		<b>20f. (City or town)</b> <span style="font-size: 1.2em;"> </span>		<b>(County)</b> <span style="font-size: 1.2em;"> </span>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <span style="font-size: 1.5em;">John T. Maloney</span>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <span style="font-size: 1.2em;">November 19, 1959</span>			
<b>EXAMINER'S NAME (Type)</b> <span style="font-size: 1.2em;">John T. Maloney, M.D.</span>				<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">Burial</span>			
<b>22b. DATE THEREOF</b> <span style="font-size: 1.2em;">11/23/59</span>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Ft. Lincoln Cemetery</span>		<b>22d. LOCATION (City, town, or county)</b> <span style="font-size: 1.2em;">Bladensburg, Md.</span>		<b>(State)</b> <span style="font-size: 1.2em;"> </span>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <span style="font-size: 1.2em;">Ritchie Brothers</span>				<b>ADDRESS</b> <span style="font-size: 1.2em;">Upper Marlboro, Md.</span>		<b>24a. REC'D BY REGISTRAR</b> DATE <span style="font-size: 1.2em;">NOV 25 '59</span>	
<b>24b. REGISTRAR'S SIGNATURE</b> <span style="font-size: 1.2em;">Arthur S. Frank</span>				<b>24c. REGISTRAR'S SIGNATURE</b> <span style="font-size: 1.2em;"> </span>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12888

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>1/2 day</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chapel Oaks</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pr. Geo. Gen. Hosp.</b>		d. STREET ADDRESS <b>1413 57th Place</b>	
3. NAME OF DECEASED (Type or print) <b>FLORINE JENKINS</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>3</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>19 June 1912</b>
9. AGE (In years, last b. day) <b>47 yrs</b>		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>4</b> Hours <b>48</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert L. Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Manie Thomas</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>	
17. INFORMANT <b>Arthur C. Jenkins (Husband)</b>		Address <b>Same as # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Spontaneous intracranial hemorrhage</b> <b>301X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cerebral hypertension</b> (c) <b>DUE TO</b> cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive cardiovascular disease</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Chapel Oaks</b>		(County) <b>Prince George's</b>	
(State) <b>Maryland</b>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John T. Maloney M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>4 Nov. 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11-7-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) <b>Washington</b>	
(State) <b>D.C.</b>		24a. REC'D BY REGISTRAR <b>NOV 12 '59</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>L.B. Cameron &amp; Son</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

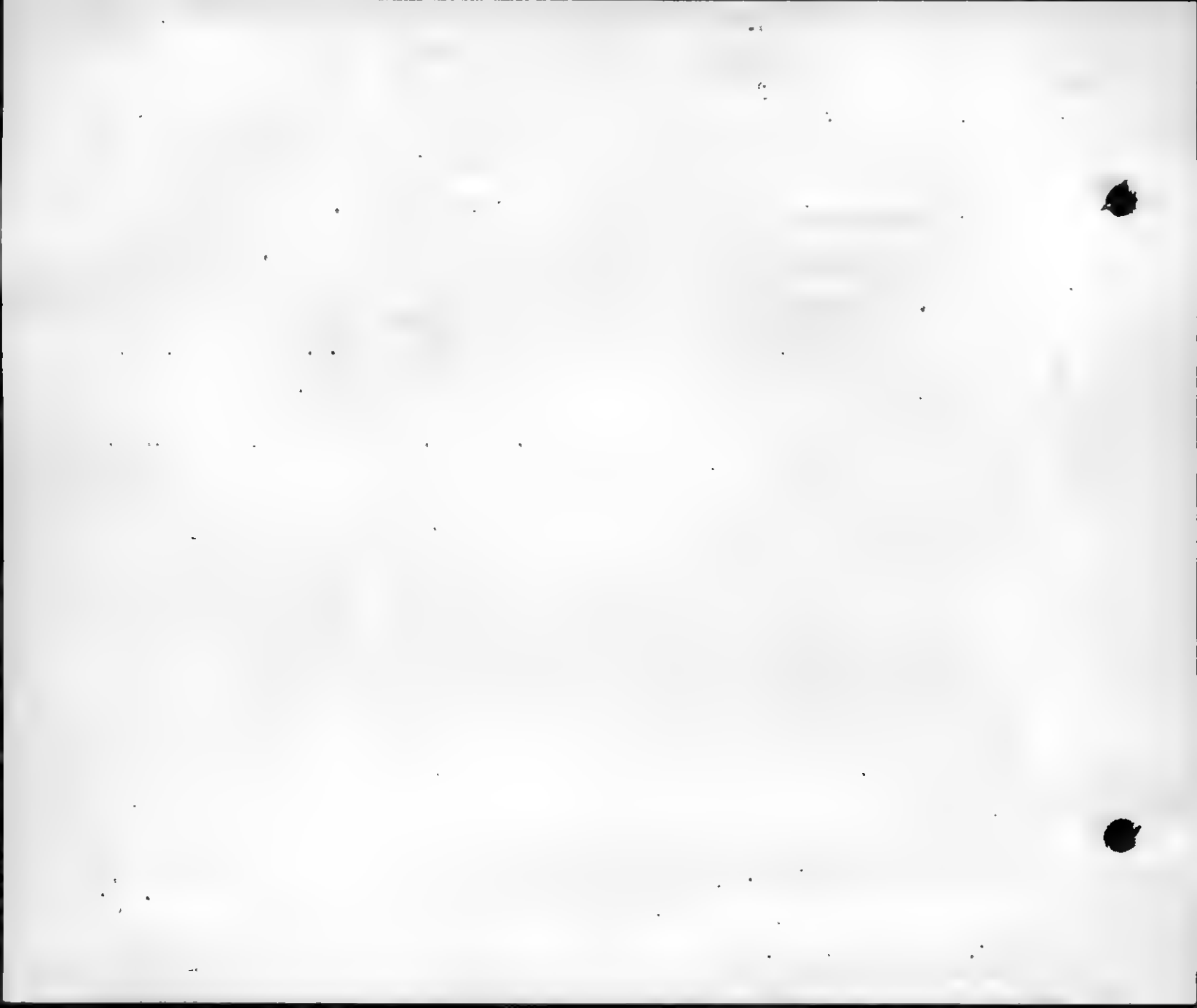
12894

CERTIFICATE OF DEATH

12889

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 15 <b>11 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brentwood</b> d. STREET ADDRESS <b>4003 Webster St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Alberta</b> Middle Last <b>Johnson</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>22,</b> Year <b>19 59</b>			
5. SEX <b>Fem.</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>7/9/1909</b>	
9. AGE (In years, say birthday) <b>50</b> yrs.		10. UNDER 1 YEAR Months Days Hours Min.		11. UNDER 24 HRS		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>G... I Chairman</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Washington, d.c.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Albert Dorsey</b>				14. MOTHER'S MAIDEN NAME <b>Joesphine Grant Simms</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.			
INFORMANT <b>Mrs. Mary G. Spriggs</b>				Address <b>18- T St. N.E.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO (b) <b>Hypertension</b> DUE TO (c) <b>Myocardial infarction</b> Conditions if any, which gave rise to immediate cause (c), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>11-13</b> , 19 <b>59</b> , to <b>11-22</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11-21</b> , 19 <b>59</b> , and that death occurred at <b>10 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>R. N. Horton</b> M.D.				ADDRESS (Street, city or town, state) <b>5432 Wisconsin Ave. N.E. Wash. D.C.</b>			
PHYSICIAN'S NAME (Type) <b>R. N. Horton</b>				DATE SIGNED <b>11/22/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>11/25/59</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Washington</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. N. Horton Co. 1322 11th St. N.E. Wash. D.C.</b>				24a. REC'D BY REGISTRAR <b>Arthur L. Hines</b>			
24b. REGISTRAR'S SIGNATURE				DATE NOV 24 '59			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Item 9 Film 6252 11-23-59 et

12890

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Accokeek</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X ACCOKEEK MD.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>NONE</u>				d. STREET ADDRESS <u>1 HWY. #283</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Emma Johnson</u>				4. DATE OF DEATH Month Day Year <u>11-16-1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 10 1873</u>	
9. AGE (In years less birthday) <u>86</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT Home</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>				13. FATHER'S NAME <u>Simon Robinson</u>			
14. MOTHER'S MAIDEN NAME <u>MARTHA GITTINGS</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NONE</u>			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>MRS. COLEMAN BADO</u> Address <u>470 WESTMORLAND AVE. TAKOMA PK. MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROSIS</u> DUE TO (b) <u>CEREBROSCLEROSIS</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 YRS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9-7-</u> , 19 <u>57</u> , to <u>11-16-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11-16-</u> , 19 <u>59</u> , and that death occurred at <u>12:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul Chen</u> M.D.				ADDRESS (Street, city or town, state) <u>Accokeek, MD.</u>			
DATE SIGNED <u>PAUL CHEN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>NOV. 19, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASHINGTON</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. CNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>RINALDI FUNERAL HOME</u> ADDRESS <u>816 H St. N.E. WASH. D.C.</u>				24a. REC'D BY REGISTRAR <u>NOV 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12854

## CERTIFICATE OF DEATH

12891

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>C.C.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE BRANCH NURSING HOME</u>			d. STREET ADDRESS <u>2708-30th St. N.E.</u>		
3. NAME OF DECEASED (Type or print) <u>IZOLA B KENNEDY</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>24</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-18-87</u>		9. AGE (In years last birthday) <u>72</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Ralph Kennedy</u> Address <u>2708-30th St. N.E.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Visceral Failure</u> <u>45 J.O.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>2 yrs +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease, Diabetes, Rheum. Arthritis</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Hour a. s. _____ p. m. _____ Month _____ Day _____ Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I attended the deceased from <u>10/14</u> , 19 <u>58</u> , to <u>11/24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/22</u> , 19 <u>59</u> , and that death occurred at <u>6:15 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Frank M. Trozzo, Jr.</u> M.D. <u>3501 Hamilton St</u> <u>11/24/59</u> PHYSICIAN'S NAME (Type) <u>FRANK M. TROZZO JR MD.</u> <u>Hyattsville Md</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-28-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Blacksburg Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Jr.</u>		ADDRESS <u>517-11th St. S.E.</u> <u>Washington D.C.</u>	24a. REC'D BY REGISTRAR DATE <u>NOV 30 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knecht</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12892

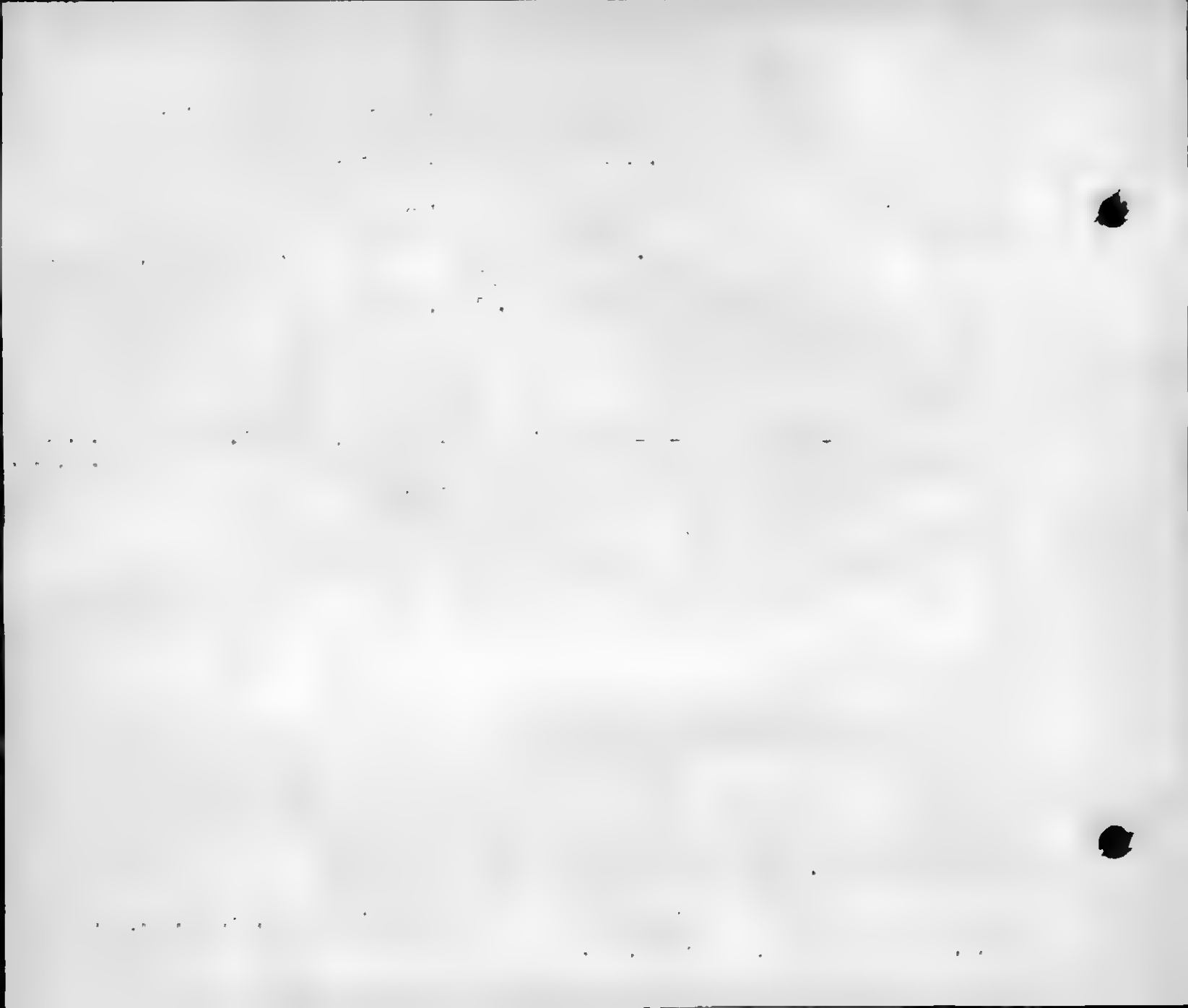
12895

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>D.O.A.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forestville</b> d. STREET ADDRESS <b>6600 D'Arcy Road</b>	
3. NAME OF DECEASED (Type or print) <b>HERMAN C. KLEIN</b>		4. DATE OF DEATH Month <b>November</b> Day <b>5th</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. <del>NEVER MARRIED</del> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>Jan. 15th, 1895</b>
9. AGE (In years last birthday) <b>64</b> yrs.		10. UNDER 1 YEAR Months <b>5</b> Days <b>10</b>	11. UNDER 24 HRS. Hours <b>10</b> Min. <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cemetery</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>WW1 1918-1919</b>		16. SOCIAL SECURITY NO <b>577-16-2806A</b>	
17. INFORMANT <b>William W. Edmunds, 5231 St. Barnabas Rd. S.E. Wash. 21, D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cardio vascular renal disease</b> (c) <b>Cardio vascular renal disease</b> cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Wash. 21, D.C.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. <b>19</b> p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>James I. Boyd</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>		DATE SIGNED <b>11/6/1959</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/10/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland Rd. Pr. Geo. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Company, Riverdale, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 10 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>C. W. B. Kram</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 File 6252 11-27-59 et

## CERTIFICATE OF DEATH

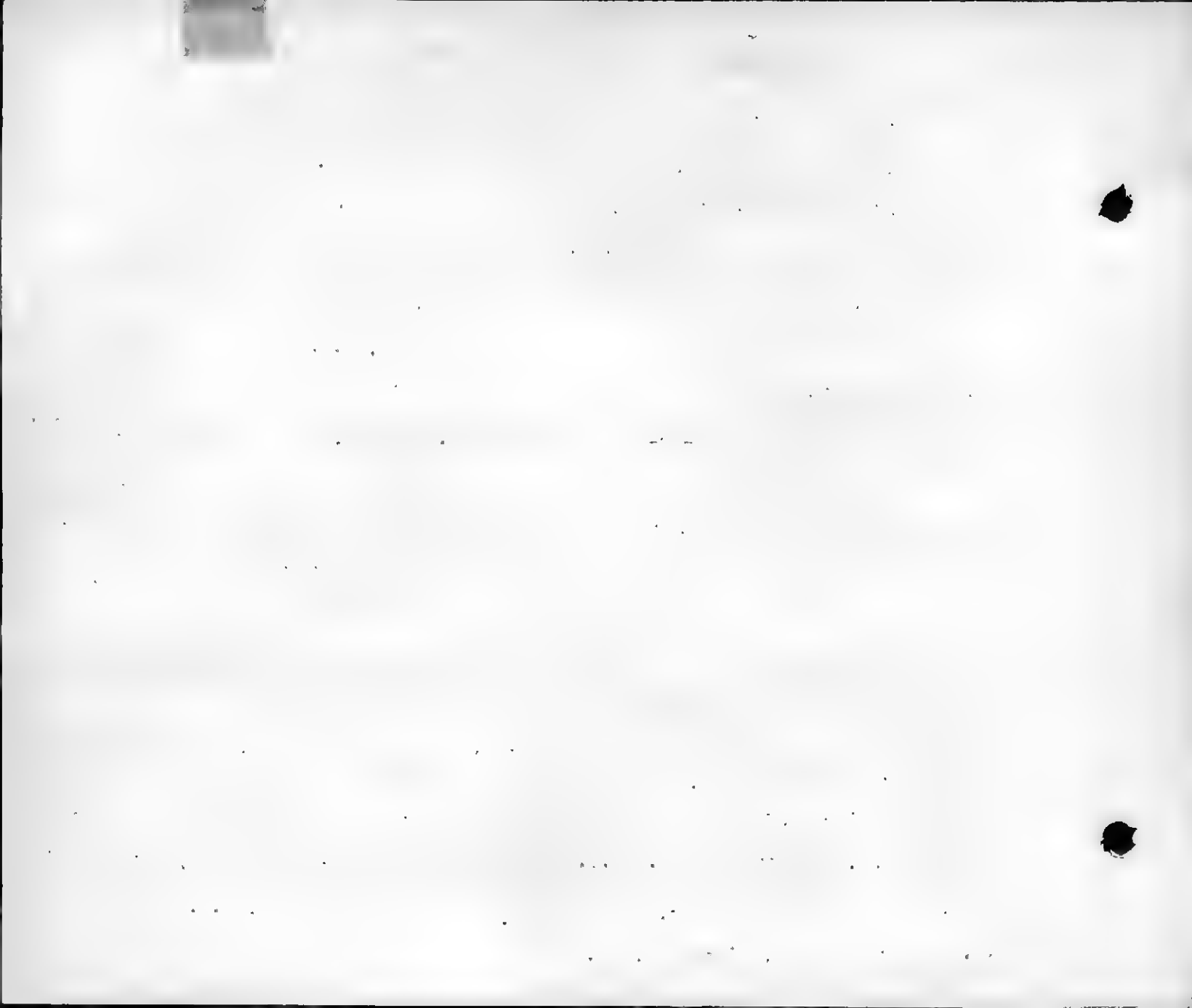
12893

Reg. Dist. No.

12896

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <b>5321 Greenway Driver</b>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>William</b> Last <b>Kreamer</b>				4. DATE OF DEATH Month <b>Nov</b> Day <b>18</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7 Feb 1907</b>	
9. AGE (In years last birthday) <b>52 yrs.</b>		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b> Hours <b>1</b> Min <b>0</b>		11. IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Bakery</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	
13. FATHER'S NAME <b>Charles Kreamer</b>				14. MOTHER'S MAIDEN NAME <b>Daisy Mary Dove</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>577-10-8365</b>		INFORMANT <b>Margaret A. Kreamer, 5321 Greenway Drive</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>471X Bronchopneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>And Malnutrition, metabolic acidosis</b> <b>Esophagospasm, Chronic</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 wks</b> <b>1 yr.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>September 19 59</b> to <b>Nov. 18 19 59</b> that I last saw the deceased alive on <b>Nov 18 1959</b> , and that death occurred at <b>6:00A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William D. Rosson M.D.</b>				ADDRESS (Street, city or town, state) <b>5304 Annapolis Road</b>			
PHYSICIAN'S NAME (Type) <b>Dr. William Rosson ., M.D.</b>				DATE SIGNED <b>11/18/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>11/21/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Company, Riverdale, Md.</b>				24a. REC'D BY REGISTRAR <b>NOV 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12855  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		c. LENGTH OF STAY IN 1b <i>6 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>15 Hyattsville,</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>814 Talbert Lane.</i>				d. STREET ADDRESS <i>1814 Talbert Lane</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Lucy</i> Middle <i>Eleanor</i> Last <i>Kuhn.</i>				4. DATE OF DEATH Month <i>November</i> Day <i>6</i> Year <i>1959</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>Caucasian</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>April 1, 1869</i>	
9. AGE (In years last birthday) <i>90</i> yrs.		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.		11. IF UNDER 24 HRS Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired photographer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Photography.</i>		11. BIRTHPLACE (State or foreign country) <i>Penn.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>							
13. FATHER'S NAME <i>Joshua Jones.</i>				14. MOTHER'S MAIDEN NAME <i>Mary Ann Bullers.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>				16. SOCIAL SECURITY NO. <i>none.</i>		INFORMANT <i>Mrs. M. Campbell.</i> Address <i>814 Talbert Lane.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart failure.</i> 4. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Heart Disease.</i> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <i>10 days.</i> <i>30 yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>chronic. Bronchitis.</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept. 28, 1959</i> to <i>Nov. 6, 1959</i> that I last saw the deceased alive on <i>Nov 6, 1959</i> , and that death occurred at <i>8:30 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Charles W. Humphreys, Jr.</i> M.D.				ADDRESS (Street, city or town, state) <i>1746 K St. N.W. Wash. D.C.</i> DATE SIGNED <i>11/6/59</i>			
PHYSICIAN'S NAME (Type) <i>Charles W. Humphreys, Jr.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		22b. DATE THEREOF <i>11/8/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Brookville Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Brookville, Pennsylvania</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co.-2901 14th St., N.W.</i>				ADDRESS <i>Wash. D.C.</i>		24a. REC'D BY REGISTRAR <i>NOV 9 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Charles S. Hines</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



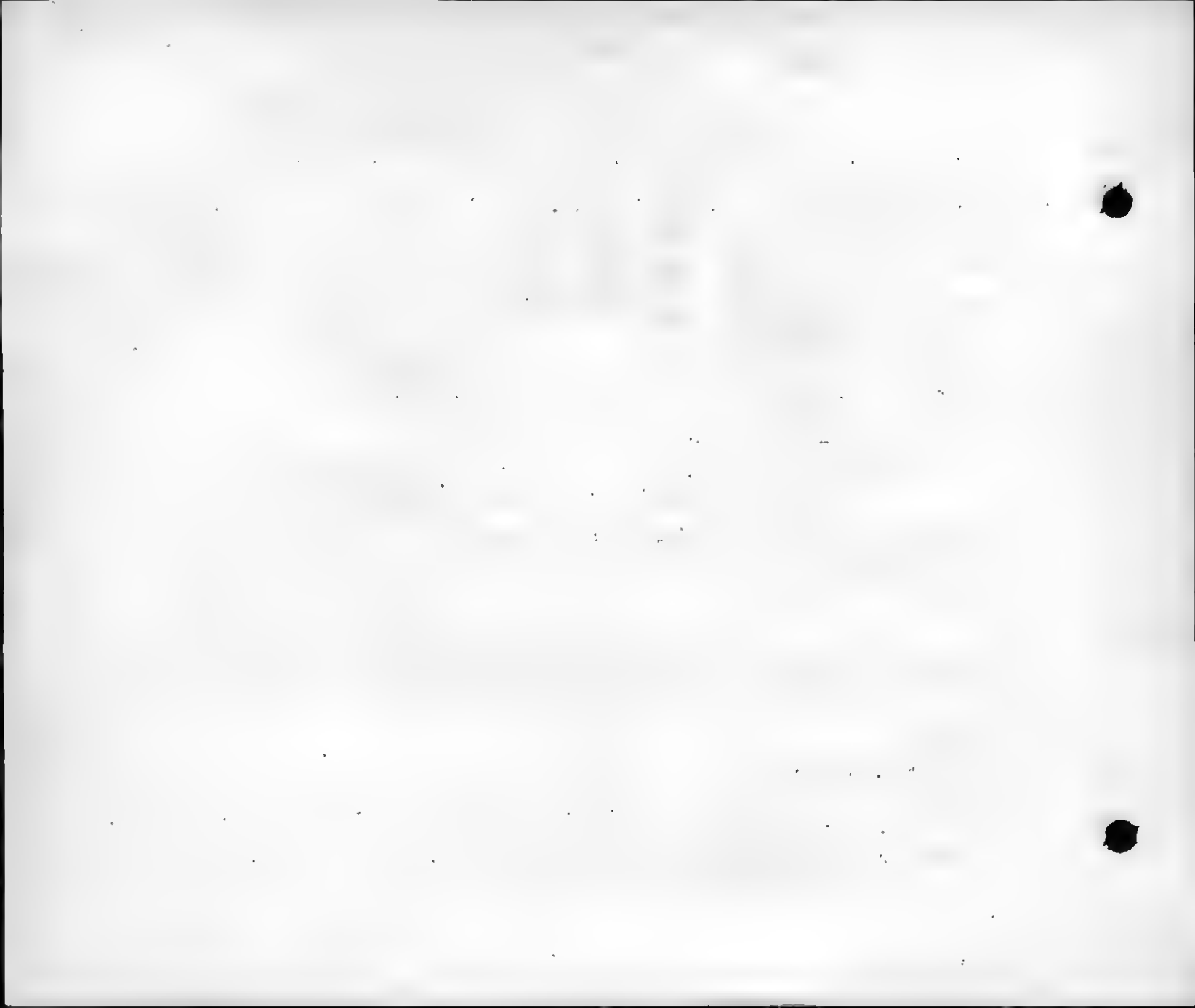
12940

## CERTIFICATE OF DEATH

Reg. Dist. No.

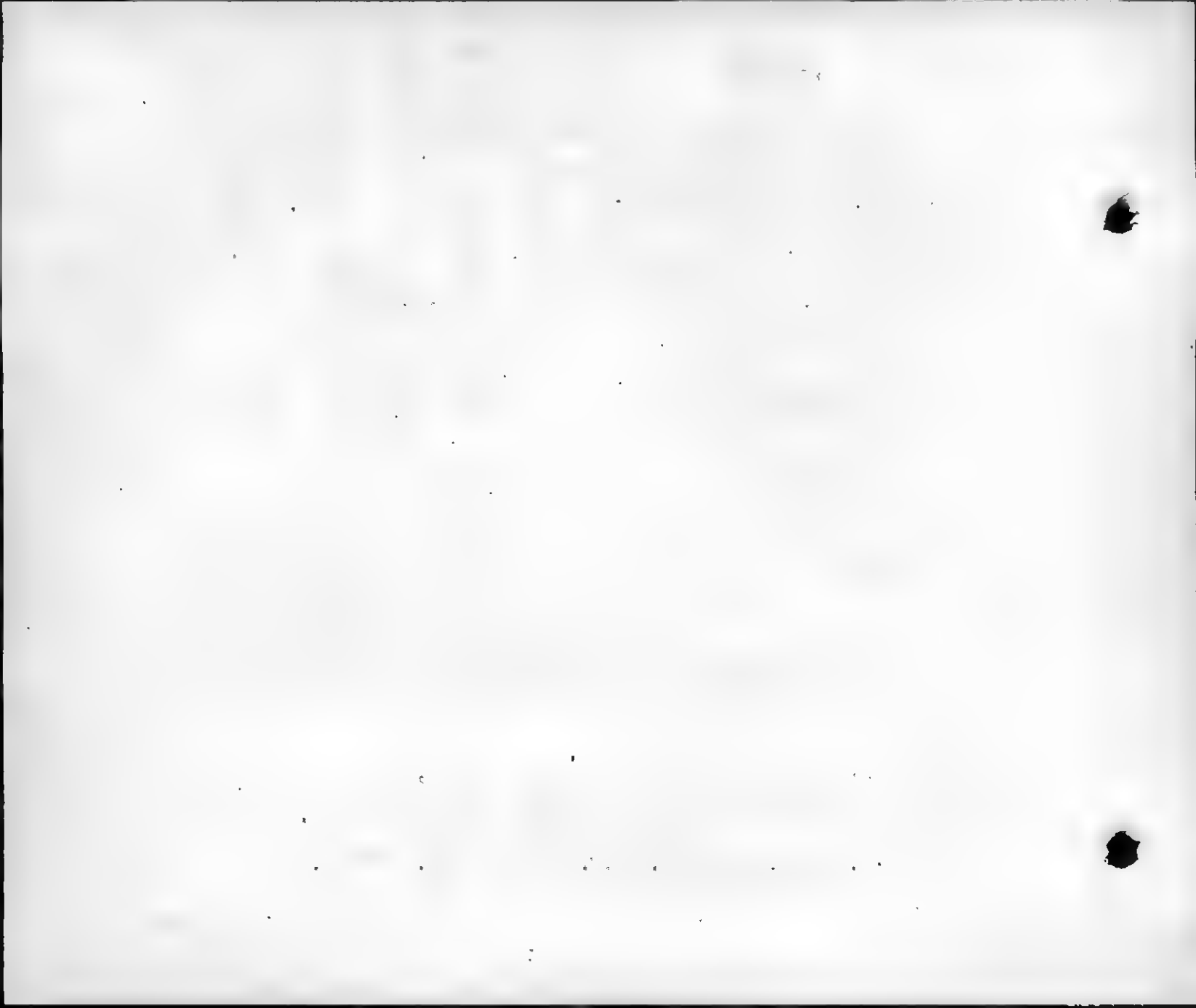
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMP SPRINGS</b>		c. LENGTH OF STAY IN 1b <b>3 DAYS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o STATE <b>DISTRICT OF COLUMBIA</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON, D.C.</b>		d. STREET ADDRESS <b>14 DANBURY STREET, S.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>DANIEL</b> Middle <b>GLENN</b> Last <b>LEMASTER</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>25</b> Year <b>1959</b>		5. SEX <b>MALE</b>		6. COLOR OR RACE <b>CAU</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>22 NOV 1959</b>		9. AGE (In years last birthday) yrs. <b>3</b>		10. IF UNDER 1 YEAR Months <b>3</b>		11. IF UNDER 24 HRS Hours <b>3</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>											
13. FATHER'S NAME <b>JAMES A. LEMASTER</b>				14. MOTHER'S MAIDEN NAME <b>ALICE KISER</b>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <b>N/A</b>		INFORMANT <b>HOSPITAL CHART</b>		Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Right middle lobe lobar pneumonia</b> <b>7:30</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <b>Undetermined</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)															
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that I attended the deceased from <b>22 November, 1959</b> , to <b>25 November, 1959</b> , that I last saw the deceased alive on <b>25 November, 1959</b> , and that death occurred at <b>1135A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED																	
ACTUAL SIGNATURE <i>Salvatore Battiatto</i>		M.D. <b>USAF HOSP ANDREWS AFB WASH 25, D.C.</b>															
PHYSICIAN'S NAME (Type) <b>SALVATORE BATTIATA CAPT USAF MC</b>		<b>USAF HOSP ANDREWS AFB WASH 25, D.C.</b>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 30, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Washington Nat Cemetery</b>		22d. LOCATION (City, town, or county) <b>Washington D.C.</b>		(State)									
23. FUNERAL DIRECTOR'S SIGNATURE <i>Funeral Home</i>				ADDRESS <b>4 Pt. N.E. Mark 2 St.</b>		24. REC'D BY REGISTRAR DATE <b>NOV 30 1959</b>		24b. REGISTRAR'S SIGNATURE <i>John S. Frank</i>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please register carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## Reg. Dist. No.

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 22, Film G252 11/17/59 iwk

## CERTIFICATE OF DEATH

Reg. Dist. No.

12898

12898

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>9 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Accokeek</u> d. STREET ADDRESS <u>Box 430</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Tra</u> Middle <u>J</u> Last <u>Lynch</u>			<b>4. DATE OF DEATH</b> Month <u>Nov</u> Day <u>14</u> Year <u>1959</u>				
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input checked="" type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>April 6, 1885</u>		<b>9. AGE</b> (In years last birthday) <u>74</u> yrs		<b>10. IF UNDER 1 YEAR</b> Months <u>7</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U S Government</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Washington D. C.</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U S A</u>				<b>13. FATHER'S NAME</b> <u>Edward Lynch</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Cummings</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>			
<b>16. SOCIAL SECURITY NO.</b> <u>A.A. Tippet, Nephew,</u>				<b>17. ADDRESS</b> <u>Same</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> 177X DUE TO <u>Congestive Heart Failure</u> (b) <u>Arterio-sclerotic heart disease</u> DUE TO <u>Cancer of prostate</u> (c) <u>lying cause lost</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u>5</u>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that I attended the deceased from</b> <u>Nov. 13, 1959</u> <b>to</b> <u>Nov. 14, 1959</u> <b>, that I last saw the deceased alive on</b> <u>Nov. 13, 1959</u> <b>, and that death occurred at</b> <u>1:20 P.M.</u> <b>from the causes and on the date stated above.</b>							
<b>ACTUAL SIGNATURE</b> <u>W. A. Little</u>		<b>ADDRESS</b> (Street, city or town, state) <u>1433 W. ...</u>		<b>DATE SIGNED</b>			
<b>PHYSICIAN'S NAME (Type)</b> <u>RONALD ...</u>		<b>M.D.</b>					
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>Nov. 17, 1959</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Evergreen Cemetery</u>			
<b>22d. LOCATION</b> (City, town, or county) <u>Bladensburg, Md.</u>		<b>(State)</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Francis ...</u>		<b>ADDRESS</b>		<b>24a. REC'D BY REGISTRAR</b> <u>NOV 17 '59</u>			
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur &amp; ...</u>							



1 ~~X~~

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

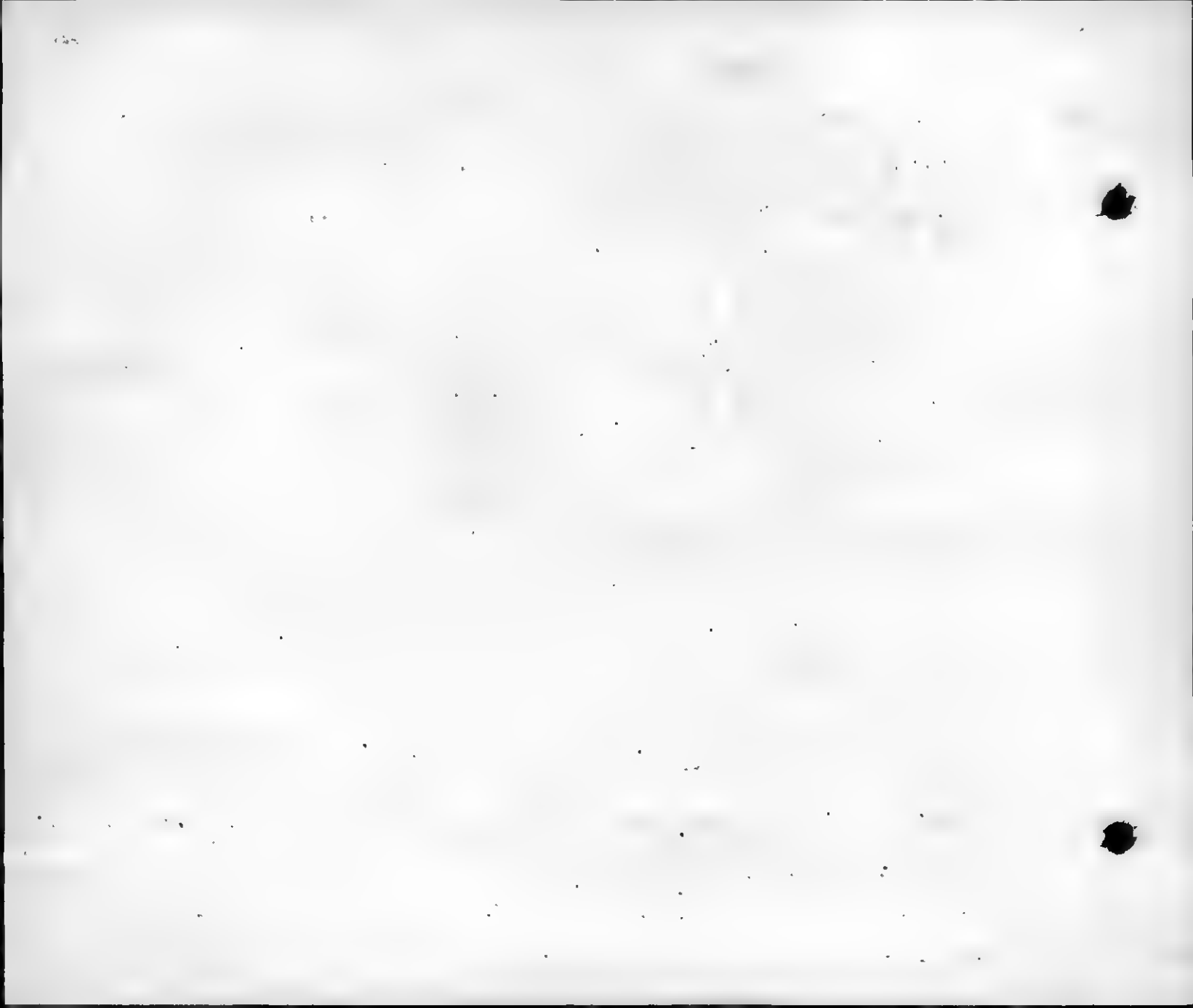
12899

## CERTIFICATE OF DEATH

Reg. Dist. No.

12899

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>1 Day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>				d. STREET ADDRESS <b>3713 34th St.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Edward Franklin Malay</b>				4. DATE OF DEATH Month Day Year <b>11-19-59</b> <b>19</b> <b>59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>4-6-25</b>	9. AGE (In years last birthday) <b>54</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington Post</b>		11. BIRTHPLACE (State or foreign country) <b>Gloucester Co., Va</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Alexander J. Malay</b>				14. MOTHER'S MAIDEN NAME <b>Virgil Mary Gwynn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>2-28-03-428</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Internal mischief from old</b> (c) <b>tuberc. pneumonia (left upper lobe)</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Intoxication, probably by alcohol, 11/17/59</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Apr. 17</b> , 19 <b>59</b> , to <b>Nov. 19</b> , 19 <b>59</b> that I last saw the deceased alive on <b>Nov. 19</b> , 19 <b>59</b> , and that death occurred at <b>8:02 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles C. Hageage</b>				ADDRESS (Street, city or town, state) <b>3308 Perry St, Mt. Rainier Md.</b>			
PHYSICIAN'S NAME (Type) <b>Charles C. Hageage</b>				DATE SIGNED <b>11/20/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/23/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Malley's Funeral Home</b>				ADDRESS <b>4000 Mt. Rainier Rd.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 23 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kincaid</b>			



12941

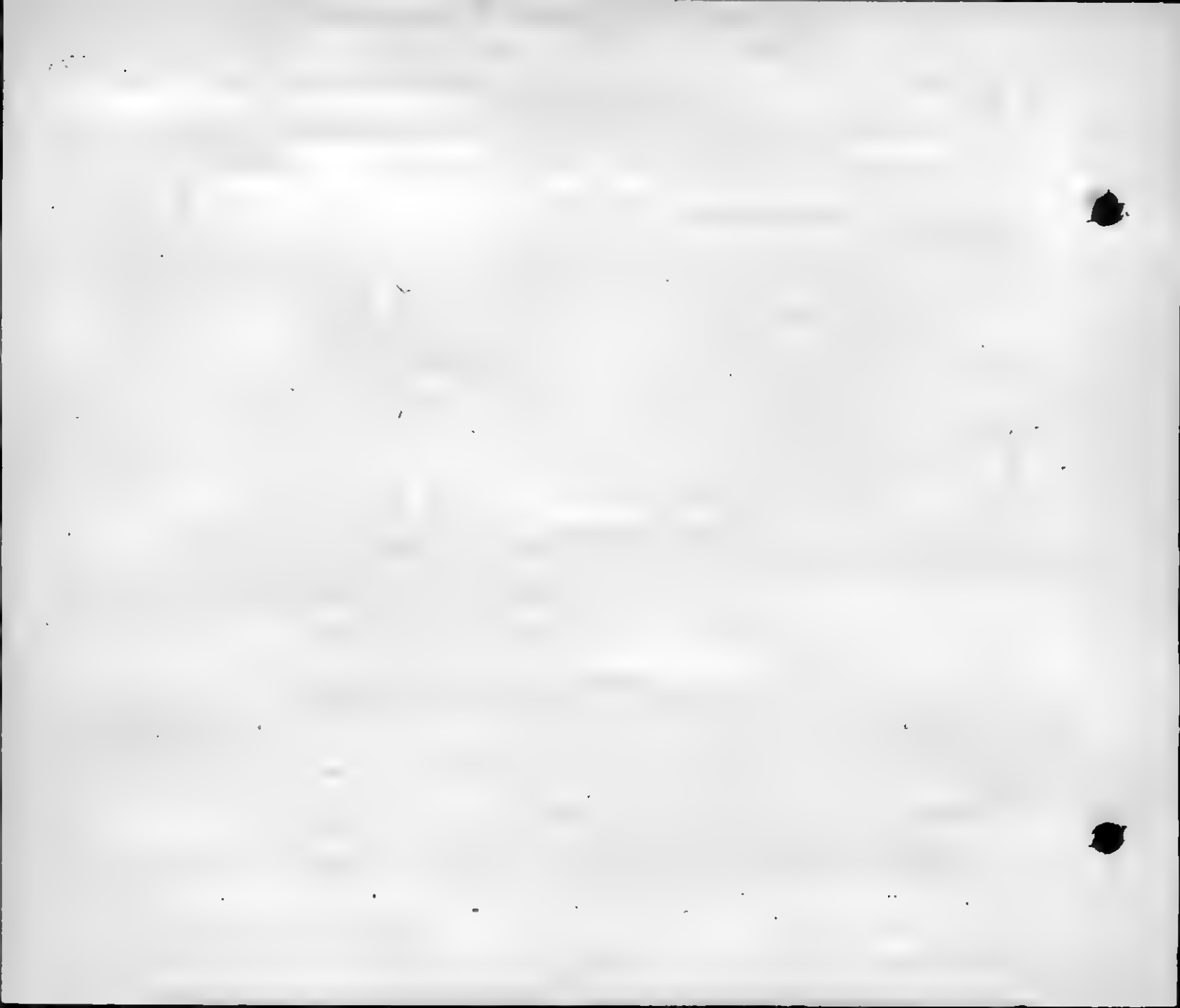
## CERTIFICATE OF DEATH

Reg. Dist. No.

12900

1 PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> c. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHILLUM</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chillum, Hyattsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>722 Rittenhouse Street</b>		d. STREET ADDRESS <b>722 - Rittenhouse street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <b>NICOLA VICTOR MANGO</b>		4. DATE OF DEATH Month Day Year <b>NOV. 29 1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 10, 1879</b>
9. AGE (In years last birthday) <b>80</b> yrs		IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>clothes designer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>	11. BIRTHPLACE (State or foreign country) <b>Italy</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Anthony Mango</b>		14. MOTHER'S MAIDEN NAME <b>Concetta Salerno</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>142-05-1395</b>	
17. INFORMANT <b>Pasquoline Mango</b>		Address <b>722 Rittenhouse St. Chillum, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>UREMIA</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>GENERALIZED ARTERIOSCLEROSIS</b> DUE TO (c) <b>10 months</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>APRIL 1957</b> to <b>NOV. 29, 1959</b> that I last saw the deceased alive on <b>NOV. 28, 1959</b> , and that death occurred at <b>9:05 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>William F. Simpson Jr.</b> M.D. <b>6216 N.H. Ave NE</b>			
PHYSICIAN'S NAME (Type) <b>William F. Simpson Jr.</b> <b>Washington D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>12/2/59</b>	<b>Fort Lincoln</b>	<b>Colmar Manor, Md</b>
23 FUNERAL DIRECTOR'S SIGNATURE <b>Valley's Funeral Home</b>		ADDRESS <b>Mt. Rainier Md.</b>	24a. REC'D BY REGISTRAR DATE <b>DEC 2 '59</b>
		24b. REGISTRAR'S SIGNATURE <b>C. L. S. Kneel</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12901

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 26 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6512 Marlboro Pike NE		d. STREET ADDRESS 16012 Marlboro Pike NE	
3. NAME OF DECEASED (Type or print) First Middle Last Maske Elizabeth Maryanne		4. DATE OF DEATH Month Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1910
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Grocery Store	11. BIRTHPLACE (State or foreign country) West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Maske	
14. MOTHER'S MAIDEN NAME Elizabeth R. Maske		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) None	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address 1411 St. Paul St. NE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Cardiac renal disease Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Diabetes		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-12-59	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Inc., Washington, D.C.		24a. REC'D BY REGISTRAR DATE NOV 16 '59	
		24b. REGISTRAR'S SIGNATURE C. H. & K. H. & K.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for to burial, cremation, or removal.

Constitutional Health Section  
U.S. Department of Health & Human Services

Director

Mr. [illegible]

James H. [illegible]  
Director

## CERTIFICATE OF DEATH

Reg. Dist. No.

12902

12943

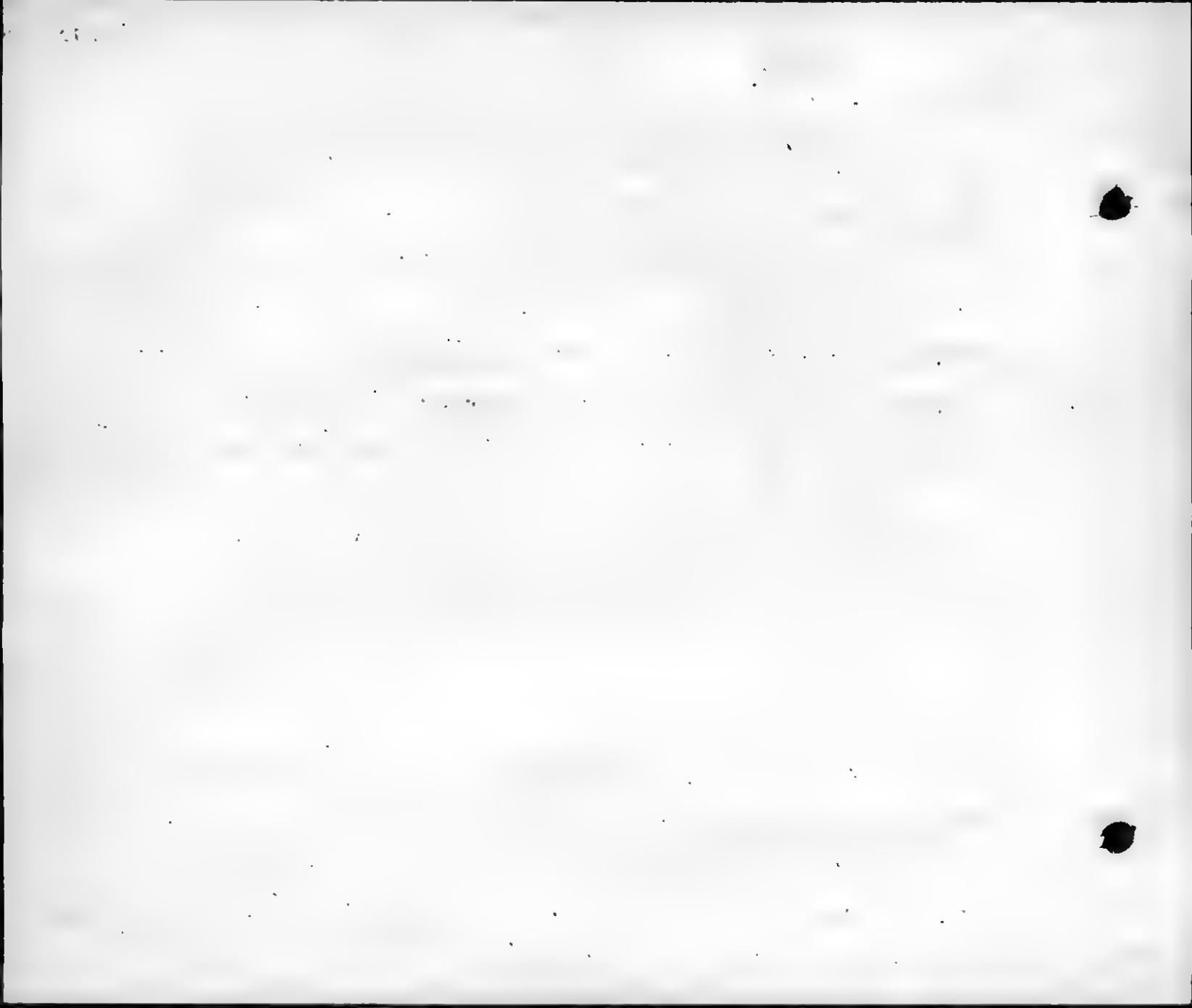
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEO</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORESTVILLE</b>				c. LENGTH OF STAY IN lb <b>2 YEARS 11 MO</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>FORESTVILLE NURSING HOME</b>				e. STREET ADDRESS <b>5918-ST. CHAIR DRIVE</b>			
3. NAME OF DECEASED (Type or print) <b>JAMES MONROE McCawley</b>				4. DATE OF DEATH <b>NOV-2-1959</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 6, 1876</b>	
9. AGE (In years last birthday) <b>83</b> yrs		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRINTER (RETIRED)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov</b>			
11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>CHARLES M. McCawley</b>				14. MOTHER'S MAIDEN NAME <b>NANCY Riggsby</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>Bessie L. McCawley</b>				Address <b>same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>GENERALIZED ARTERIOSCLEROSIS</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>15 yrs.</b>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I. of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>4-3</b> , 19 <b>53</b> , to <b>11-2</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11-1</b> , 19 <b>59</b> , and that death occurred at <b>12:30 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John B. Fegan</b> M.D.				ADDRESS (Street, city or town, state) <b>2215 NICHOLS AVE S.E.</b>			
PHYSICIAN'S NAME (Type) <b>JOHN B FEGAN, M.D.</b>				WASH D.C.			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>MAY 5-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Smithland, Maryland</b>				22e. REC'D BY REGISTRAR <b>DATE NOV 4 '59</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>SIMMONS BROS</b>				ADDRESS <b>1661 GOOD HOPE RD SE</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hinkle</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use on the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

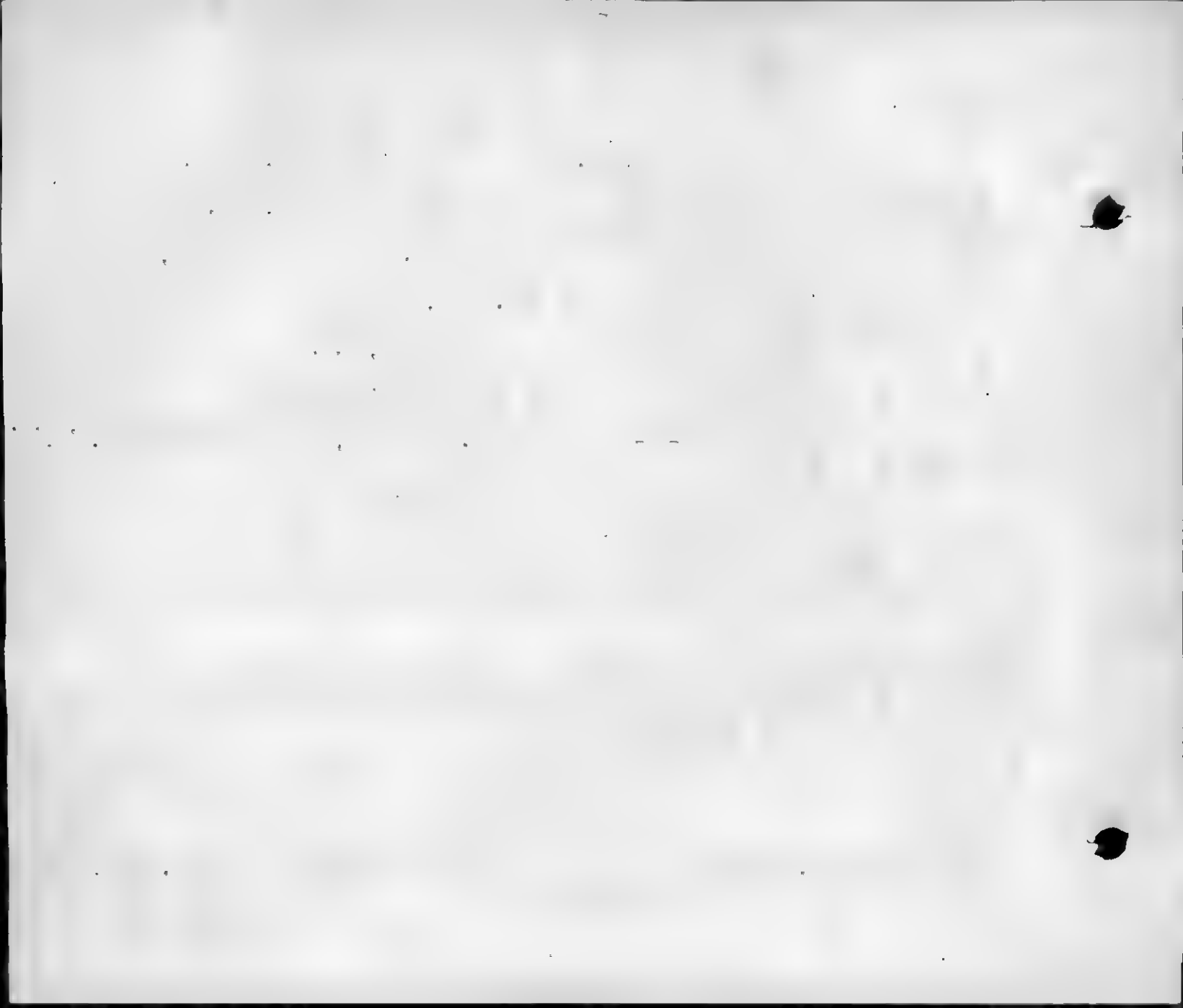
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12903

12900

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. STREET ADDRESS <b>1413 Boones Hill Road, Apt.#1</b>	
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>JOSEPH</b> Last <b>MC GEE, JR.</b>		4. DATE OF DEATH Month <b>November</b> Day <b>27th</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 24th, 1914</b>
9. AGE (In years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min IF UNDER 24 HRS: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gas Station Attendant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gasoline</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward Joseph McGee</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Liversedge</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-01-8394</b>	
17. INFORMANT <b>Edward J. McGee 111, 1413 Boones Hill Rd.S.E.</b>		Address <b>Washington 27, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>417X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Ulcerated mitral stenosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>Nov. 28th, 1959</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 30, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>DEC 1 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

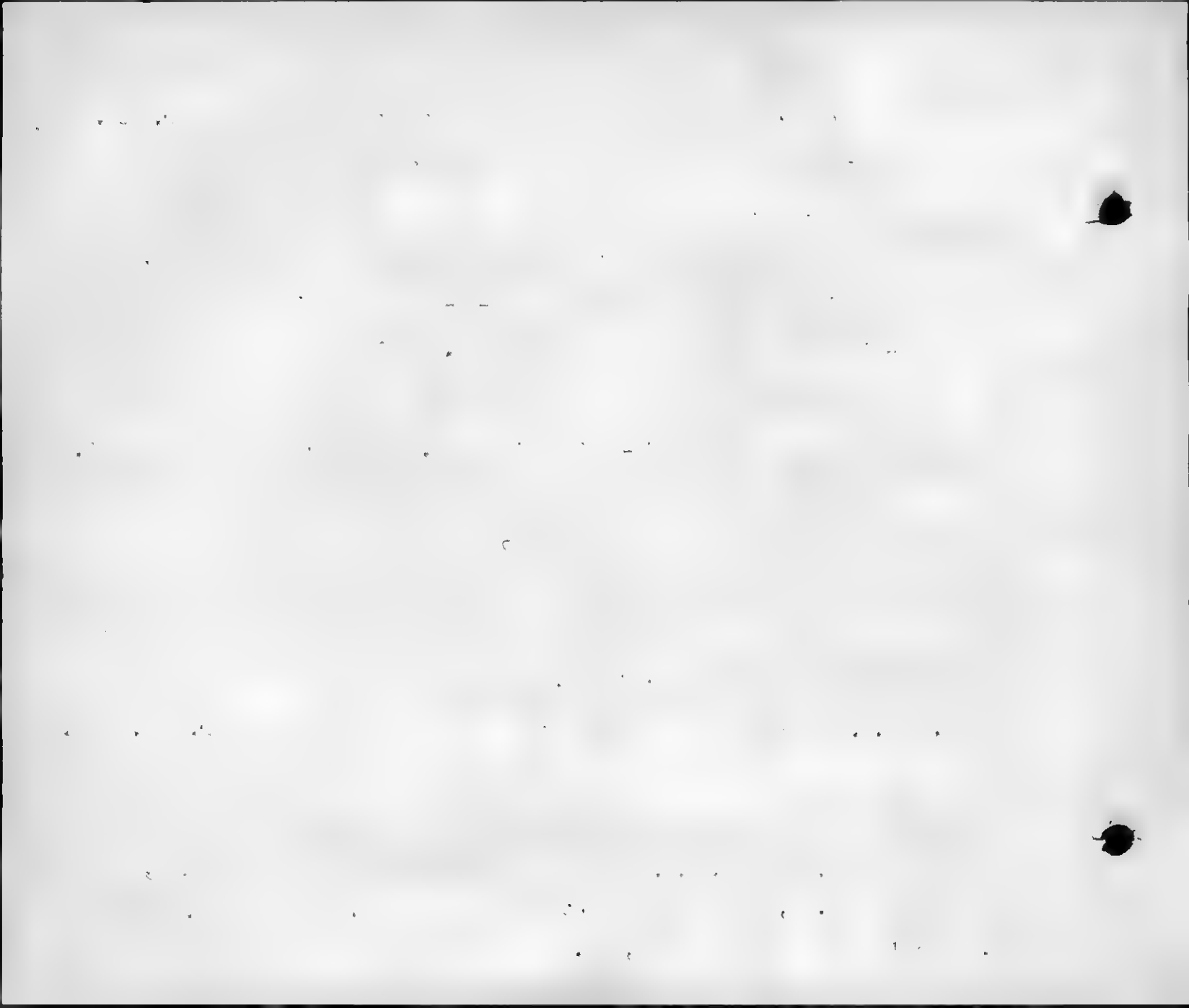
12904

Reg. Dist. No.

12856

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. LENGTH OF STAY IN 1b <b>2 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3513 54th Avenue</b>				d. STREET ADDRESS <b>3513 54th Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Juanita</b> Middle <b>Grenshaw</b> Last <b>McKibben</b>				4. DATE OF DEATH Month <b>November</b> Day <b>5</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-28-27</b>		9. AGE (In years last birthday) <b>32</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-wife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>S. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Samuel Grenshaw</b>				14. MOTHER'S MARRIED NAME <b>Elizabeth Blanche</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>248-34-2563</b>		17. INFORMANT <b>William B. McKibben; same address as #2.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> <b>476x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gunshot wound of chest</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Self inflicted wound of chest</b>					
20c. TIME OF INJURY Month, Day, Year <b>10.30 A.M. 11-5-1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>		20f. (City or town) (County) (State) <b>Hyattsville Pr. Geo. Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John T. Maloney</b>				DATE SIGNED <b>November 5, 1959</b>			
NAME (Type) <b>John T. Maloney, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. REMOVAL, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 9, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Unity Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Ft. Mill So. Carolina</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 10 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Fiana</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



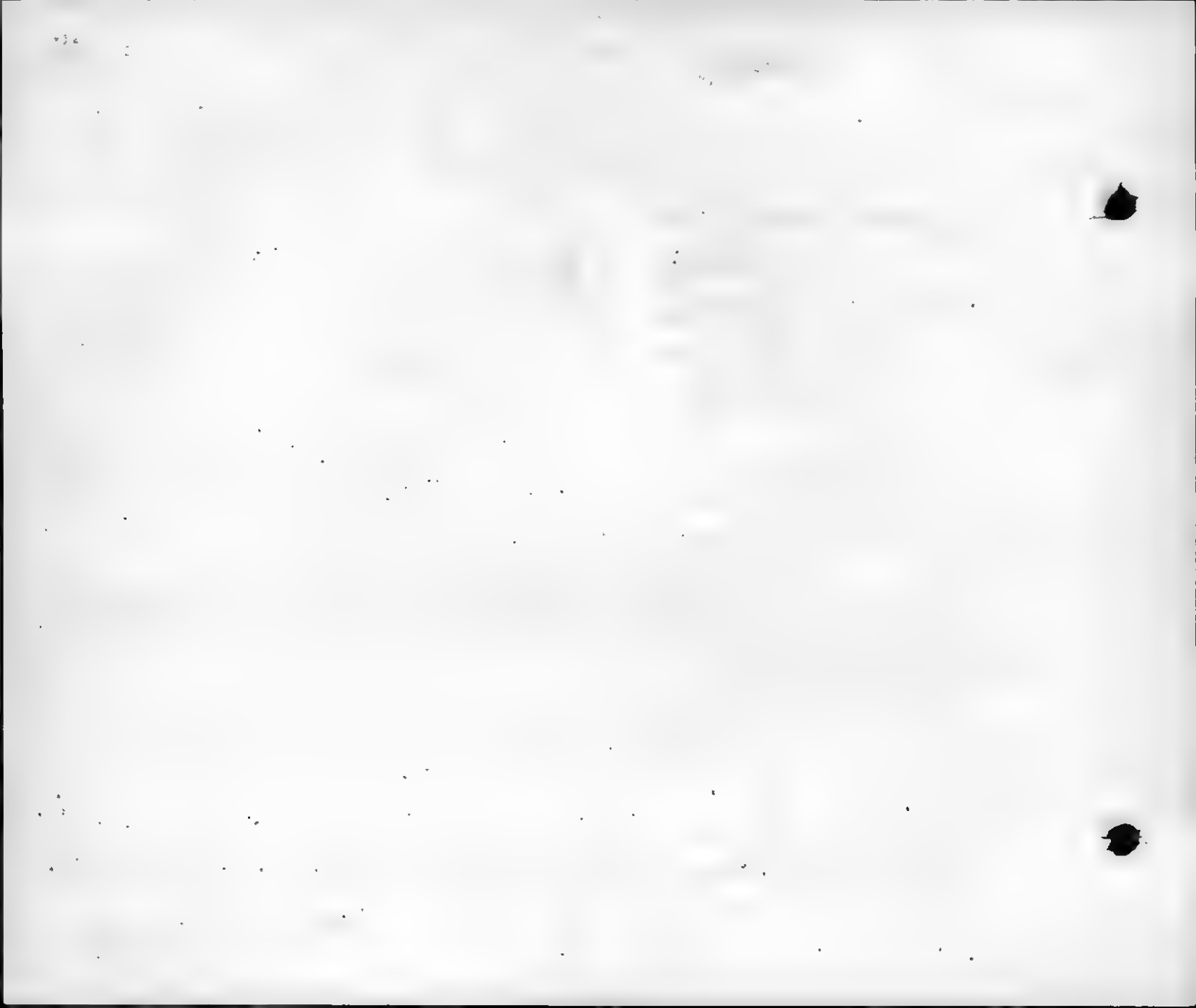
## CERTIFICATE OF DEATH

Reg. Dist. No. 12905

12901

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	
c. LENGTH OF STAY IN 1b 5 Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		d. STREET ADDRESS 3802 58 Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Barbara Mc Kinney		4. DATE OF DEATH Month Day Year November 13 19 59	
5. SEX Female F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18 1959
9. AGE (In years last birthday) yrs 5		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Robert L. Mc Kinney		14. MOTHER'S MAIDEN NAME Dorothy Godsey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Dorothy Mother Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bacteremia & hydrocephalus DUE TO (b) Ruptured aortic aneurysm & acute bronchitis DUE TO (c) acute bronchitis		INTERVAL BETWEEN ONSET AND DEATH 5 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 18, 1959, to November 13, 1959, that I last saw the deceased alive on November 13, 1959, and that death occurred at 6:45 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE William A. Stecher M.D.		ADDRESS (Street, city or town, state) 6300 Riverdale Rd., Riverdale Md.	
PHYSICIAN'S NAME (Type) William A. Stecher		6300 Riverdale Rd., Riverdale Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 16, 1959	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR DATE NOV 17 '59		24b. REGISTRAR'S SIGNATURE	

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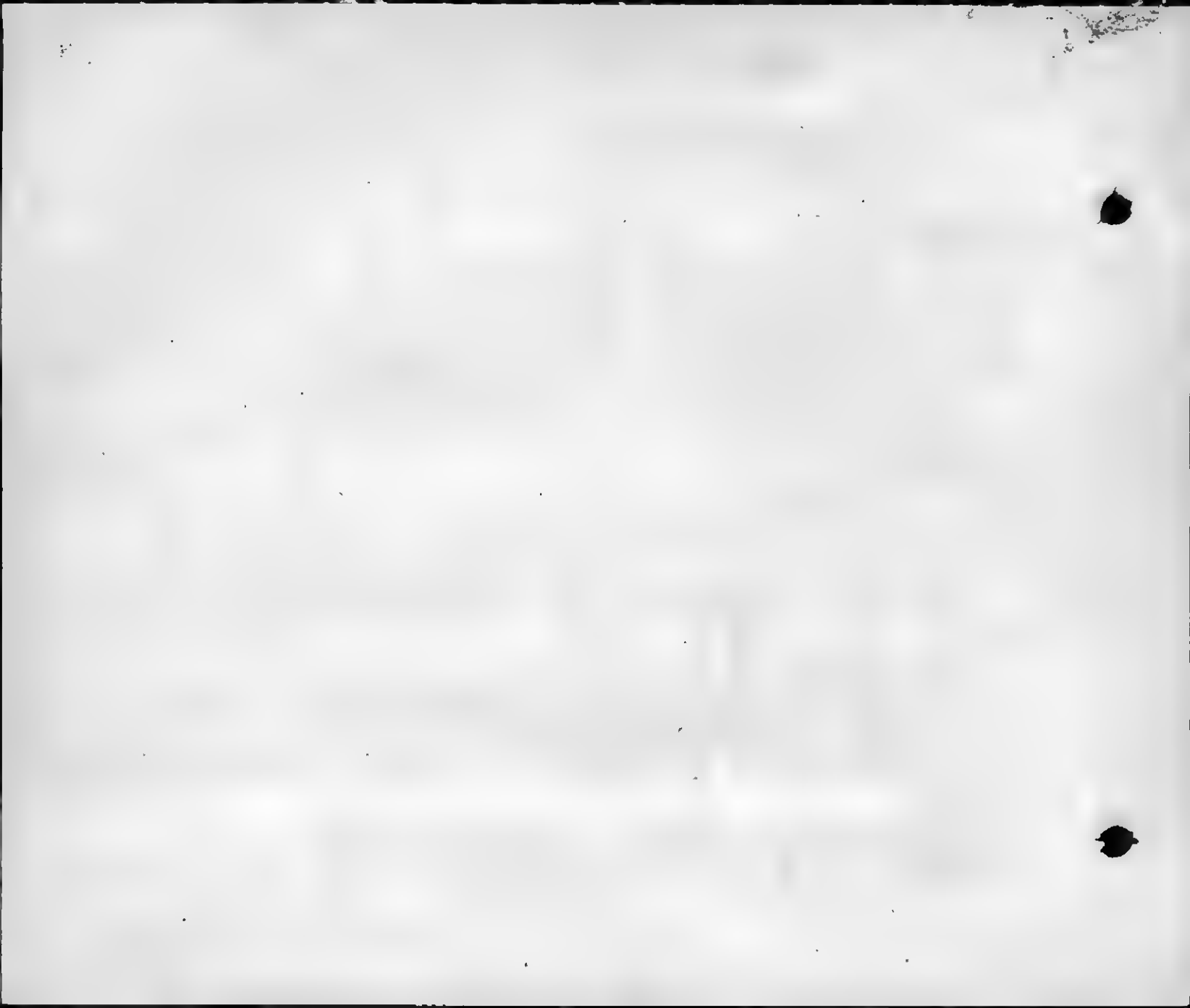
12412



1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen. Hosp</u>		d. STREET ADDRESS <u>4833 - Indian Lane</u>	
3. NAME OF DECEASED (Type or print) <u>James Arthur Melton</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-23-12</u>
9. AGE (In years last birthday) <u>47</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life. When if retired) <u>Shipping Clerk</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arthur Melton</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Dixon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Louise Ligon - College Park, Md.</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Polycystic Kidneys, Coronary atherosclerosis</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input checked="" type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>John J. Maloney</u>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Dec-1, 1959</u>	
22a. REMOVAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 2, 1959</u>	
22c. NAME OF CEMETERY OR CREMATOR <u>George Washington</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattsville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 3 '59</u>	
ADDRESS <u>Hyattsville Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## CERTIFICATE OF DEATH

Reg. Dist. No.

12907

12944

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <b>DISTRICT OF COLUMBIA</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL- GLENN DALE 7 YRS, 1 Mo, 4 Ws</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON 47</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GLENN DALE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>NELLIE C. MENDELL HALL</b>		4. DATE OF DEATH Month Day Year <b>NOV 21 1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6/9/07</b>
9. AGE (In years last birthday) <b>52 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SEAMSTRESS</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SELF-EMPLOYED</b>	
11. BIRTHPLACE (State or foreign country) <b>SALISBURY, NORTH CAR.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN W. KERR</b>		14. MOTHER'S MAIDEN NAME <b>CLARA SWAIN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>UNK.</b>	
17. INFORMANT <b>PATIENT</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PULMONARY TUBERCULOSIS</b> -DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PULMONARY INSUFFICIENCY AND COR PULMONALE</b>			INTERVAL BETWEEN ONSET AND DEATH <b>8 YRS.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I, or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>OCT 17 1952</b> to <b>NOV 21 1959</b> that I last saw the deceased alive on <b>NOV 21 1959</b> , and that death occurred at <b>1400 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Uwe Weiss</i>		DATE SIGNED <b>NOV 21 1959</b>	
PHYSICIAN'S NAME (Type) <b>MOE WEISS, M.D.</b>		<b>GLENN DALE, Md.</b>	
22a. (BURIAL) CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11-23-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Colman Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Sacchi</b>		24a. REC'D BY REGISTRAR <b>NOV 27 1959</b>	
ADDRESS <b>4739 Bell Ave, Hyattsville</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MOE WEISS, M.D. GREEN DALE, MD.  
 GREEN DALE HOSPITAL  
 NOV 31 31 OCT 17 31 NOV 31  
 11/31/52

PULMONARY INSUFFICIENCY AND COR PULMONALE

X

PULMONARY TUBERCULOSIS

8 XRS

NO

OK.

PATIENT

JOHN W. KERR

CLARK SWAIN

SEAMSTRESS

SELF-EMPLOYED SEAMSTRESS, WASHINGTON, D.C.

FEMALE WHITE

X

6/1/52

32

MELIE C. MENDENHALL

NOV 31

32

GREEN DALE HOSPITAL 3231 CENTER ST. N.W.

X

RURAL - GREEN DALE HOSPITAL

WASHINGTON

YKING GREGG

DISTRICT OF COLUMBIA

12945

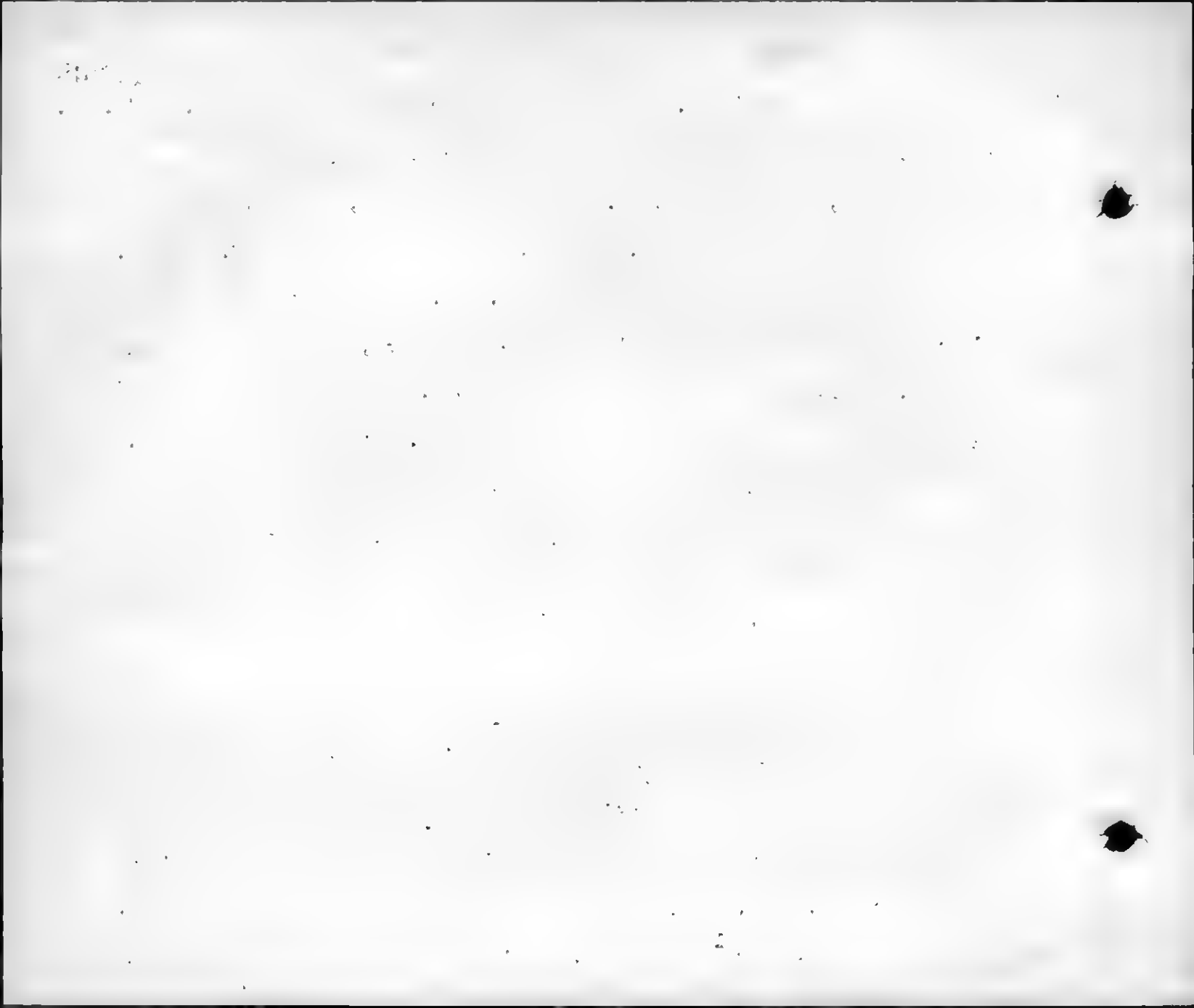
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George's Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo's. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton, Maryland		c. LENGTH OF STAY IN 1b Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Clinton, Maryland		d. NAME OF HOSPITAL (If not in hospital, give street address) Thrift Road, Clinton, Maryland.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS Thrift Road, Clinton, Maryland.	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle F. Last MULLIKIN		4. DATE OF DEATH Month NOV. Day 20th. Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 9th. 1900
9. AGE (In years last birthday) yrs. 58		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Campbell's Hardware	
11. BIRTHPLACE (State or foreign country) Clinton, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John H. Mullikin		14. MOTHER'S MAIDEN NAME Mary O. Palmer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO 578-07-2249	
INFORMANT Mrs. Alice O. Mullikin		Address Same as # 2.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Congestive Cardiac Failure</u> DUE TO (b) <u>Cardiovascular Renal Disease</u> DUE TO (c) <u>_____</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dilated Myocardium for one year</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>_____</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>_____</u>		20f. (City or town) (County) (State) <u>_____</u>	
21. I certify that I attended the deceased from Jan 1, 1959, to Nov 20, 1959, that I last saw the deceased alive on Nov 15, 1959, and that death occurred at 3:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Paul C Van Hatten</u> M.D. <u>5440 Silver Hill Rd SE</u> PHYSICIAN'S NAME (Type) <u>PAUL C VAN HATTEN</u> <u>Washington D.C.</u>			
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 23rd. 59	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros.</u>		24a. REC'D BY REGISTRAR DATE NOV 23 '59	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

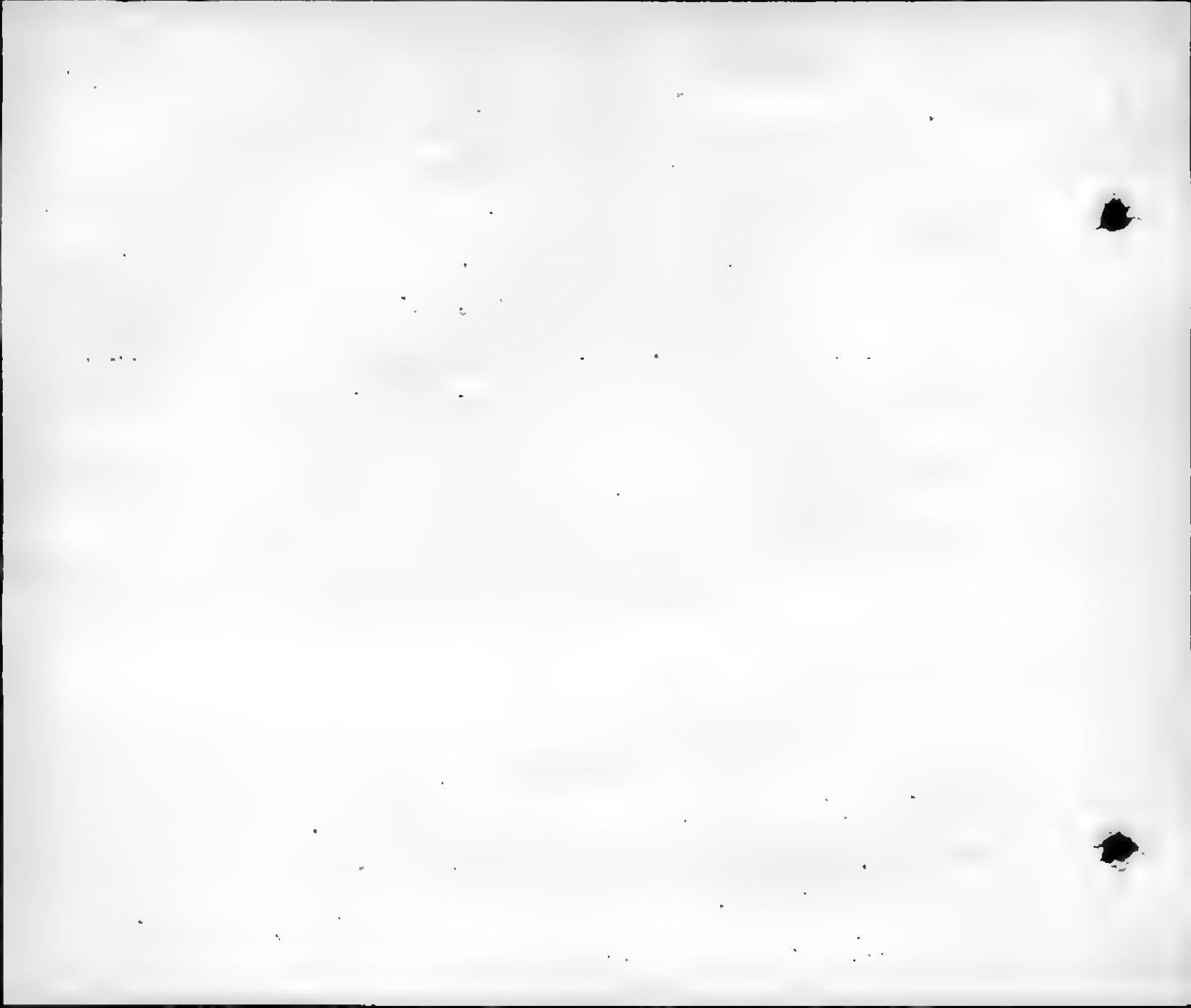
## CERTIFICATE OF DEATH

Reg. Dist. No. **12909**

**12903**

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b> <b>Prince George</b>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>12 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>No Laurel</b> <b>13X-</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>				d. STREET ADDRESS <b>6th</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John</b> First <b>Ereutt</b> Middle <b>Baby</b> Last <b>Boy Mullis</b>				4. DATE OF DEATH Month <b>Nov</b> Day <b>14</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov 2, 1959</b>	
9. AGE (In years lost birthday) yrs		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>6</b> Hours <b>5</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Marylan</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>one</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Marylan</b>	
13. FATHER'S NAME <b>Forrest Mullis</b>				14. MOTHER'S MAIDEN NAME <b>Nancy Gail Van Alstine</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>Parents</b>		INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>776X</b> DUE TO <b>Prematurity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 2</b> , 1959, to <b>Nov 14</b> , 1959, that I last saw the deceased alive on <b>Nov 14</b> , 1959, and that death occurred at <b>2:25 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>John R Buell</b> M.D. <b>420 1/2 Main St.</b> PHYSICIAN'S NAME (Type) <b>Dr. John Buell</b> <b>Laurel M d.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/16/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sanage cem</b>		22d. LOCATION (City, town, or county) (State) <b>Sanage Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>McWitt Macallan</b>				ADDRESS <b>Laurel Md</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 18 '59</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krasak</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12904

CERTIFICATE OF DEATH

Reg. Dist. No.

12910

1. PLACE OF DEATH a. COUNTY <u>Prince George Co., MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leland Memorial Hosp.</u>				d. STREET ADDRESS <u>56 C Ridge Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Michael</u> Last <u>Newcomb</u>				4. DATE OF DEATH Month <u>November</u> Day <u>12</u> Year <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-13-99</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>line foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>C-P Telephone Co</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Edward Newcomb</u>				14. MOTHER'S MAIDEN NAME <u>Mary Wagner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Hosp. Record - Leland Memorial Hosp.</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>44</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from <u>11-7-58</u> , 19 <u>58</u> , to <u>11-12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11-12</u> , 19 <u>59</u> , and that death occurred at <u>4:50 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>D.R. Purdie</u>				ADDRESS (Street, city or town, state) <u>4404 Queensbury Rd., Riverdale, Md.</u>			
DATE SIGNED <u>11-12-59</u>							
PHYSICIAN'S NAME (Type) <u>D. R. Purdie MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>11-16-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. James Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. G. Ditterly</u> ADDRESS <u>131-112th St. S.E.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u></u>	



12946

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland c. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick H.T.S.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Fremont Heights	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1032-58th Ave.		d. STREET ADDRESS 1032-58th Ave.	
3. NAME OF DECEASED (Type or print) Bertha Nelson Harris		4. DATE OF DEATH Nov. 30 1959	
5. SEX fe	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-3-1909
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Berry		14. MOTHER'S MAIDEN NAME Bertha Irene Gansert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 17. INFORMANT Ethel M. Davis - 4020 Alameda St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-vascular (intermediate) - softening of heart 13X DUE TO (b) Hypertensive Cardio-vascular Disease DUE TO (c) C.V.A. Hemorrhage 10/18/59		INTERVAL BETWEEN ONSET AND DEATH 28	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-20-1959, to 11-30-1959, that I last saw the deceased alive on 11-20-1959, and that death occurred at 2: P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John W. Robinson, M.D.		ADDRESS (Street, city or town, state) 1001 Eastview Ave. N.E. 11/10/59	
PHYSICIAN'S NAME (Type) John W. Robinson, M.D.		WASHINGTON 27, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/5/59	
22c. NAME OF CEMETERY OR CREMATORY WOODLAWN		22d. LOCATION (City, town, or county) (State) WASH., D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles Stewart - 30 State St.		ADDRESS	
24a. REC'D BY REGISTRAR DATE DEC 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the state records office.

FOI  
HEAL

STATE HEALTH DEPT.  
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

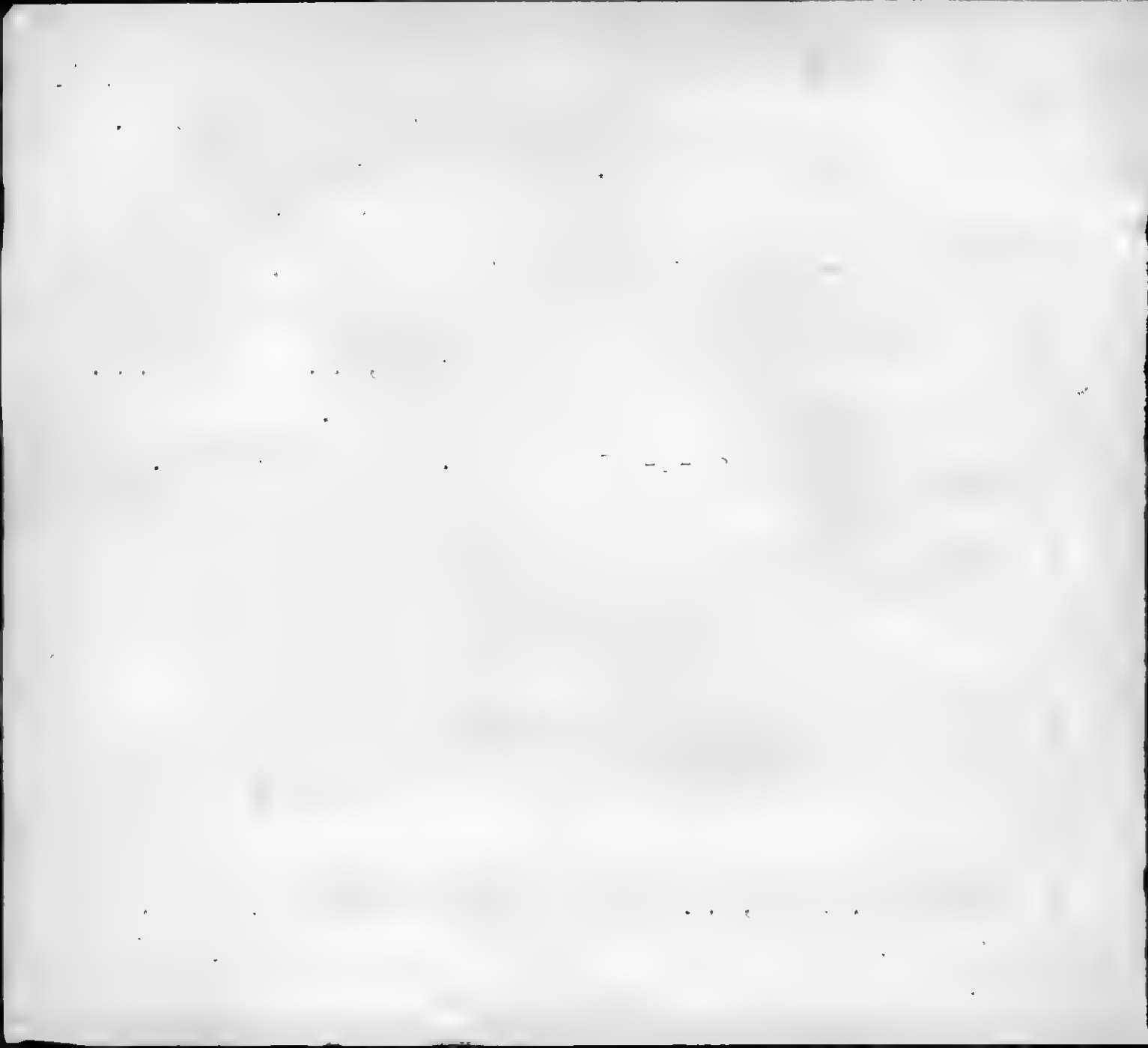
12858

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12912

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Rainier</b>		c. LENGTH OF STAY IN TB <b>52 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Rainier</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4208 34th Street</b>			d. STREET ADDRESS <b>4208 34th Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Edward Calvin Norton</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>11</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/26/06</b>		9. AGE (In years last birthday) <b>52 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stone mason</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	
10c. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Amos Leonard Norton</b>			14. MOTHER'S MAIDEN NAME <b>Grace L.</b>		
15. WAS DECEASED EVER IN ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			16. SOCIAL SECURITY NO. <b>219-03-4331</b>		
17. INFORMANT <b>Bernadine M. Parnell; Riverdale, Md.</b>			Address <b>5707 Longfellow</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular renal disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>John T. Maloney</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>November 11, 1959</b> NAME (Type) <b>John T. Maloney, M.D.</b> 22a. BURIAL, CREMAT OR REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>11/16/59</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b> 22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b> 23. FUNERAL DIRECTOR'S SIGNATURE <b>Nalley's Funeral Home</b> ADDRESS <b>Mt Rainier</b> 24a. REC'D BY REGISTRAR <b>DATE NOV 16 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur &amp; Anna</b>					



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12913

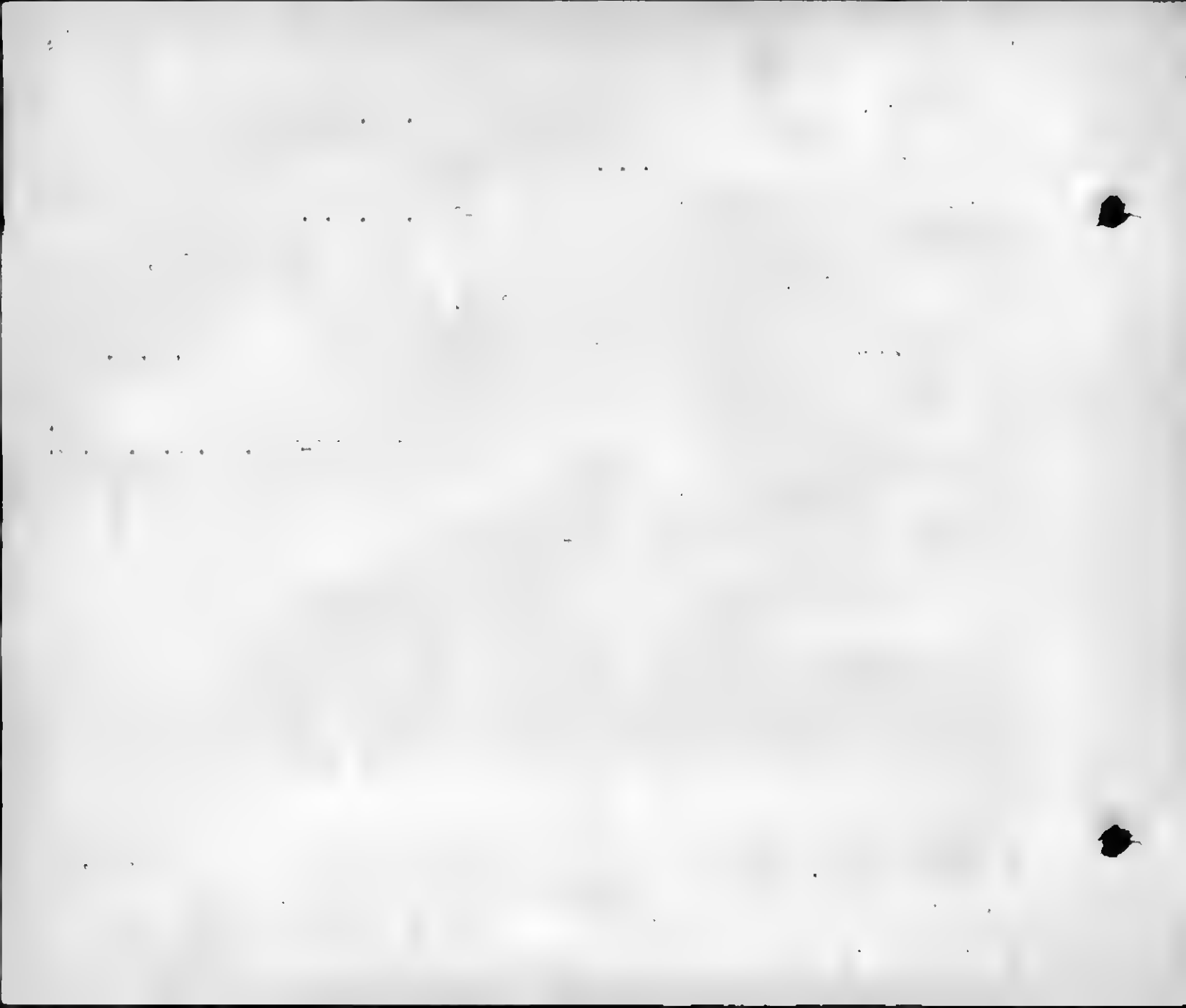
12905

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> 47x-	
f. STREET ADDRESS <b>341-11th. St. S.E.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>NICOLOS LEE ORES</b>		4. DATE OF DEATH <b>November 5th, 1959</b>	
5. SEX <b>Male</b>	6. COLOR <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 5, 1920</b>
9. AGE (in years last birthday) <b>39</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>GEORGIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Idell Ores (Wife)</b>		Address <b>Wash. 341-11th. St. S. E. D. C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary athero-sclerosis</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James I. Boyd</i>		DATE SIGNED <b>Nov. 5th, 1959</b>	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11-12-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN</b>	22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, DC.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John T. Rhines + Co-395-12th</i>		24a. REC'D BY REGISTRAR <b>NOV 12 '59</b>	
ADDRESS <b>Washington D.C.</b>		24b. REGISTRAR'S SIGNATURE <i>Carlton S. Thomas</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



12947

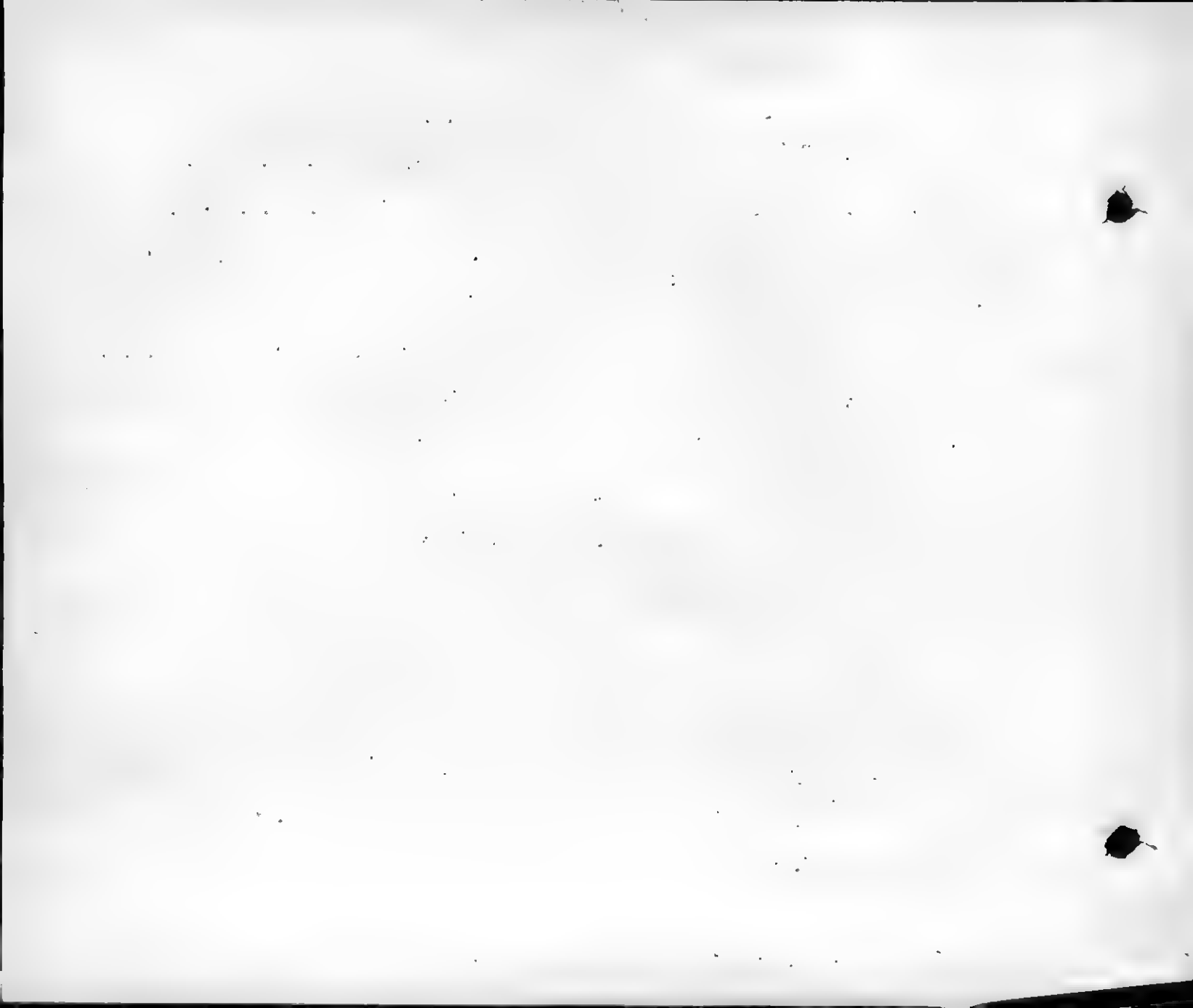
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (RURAL)</b>				c. LENGTH OF STAY IN 1b <b>18 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenn Dale Hospital</b>				d. STREET ADDRESS <b>813 - 5th St., N.W., Apt. 7</b>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Peatross</b> Last <b>Peatross</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>10</b> Year <b>19 59</b>			
5 SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/18/96</b>		9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Pittsylvania Co., Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Peatross</b>				14. MOTHER'S MAIDEN NAME <b>Annie Cunningham</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>lost</b>		INFORMANT <b>Decedent</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intestinal obstruction</b> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Tuberculous peritonitis</b> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>5 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 23</b> , 19 <b>59</b> , to <b>Nov. 10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>November 10</b> , 19 <b>59</b> , and that death occurred at <b>1:15 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Moe Weiss</b>		M.D. <b>Glenn Dale Hospital, Maryland</b>		ADDRESS (Street, city or town, state) <b>Washington, D. C.</b>		DATE SIGNED <b>11/10/59</b>	
PHYSICIAN'S NAME (Type) <b>Moe Weiss</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>11-10-59</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George L. Better</b>				ADDRESS <b>1203 Walter St.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 16 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur E. Thomas</b>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

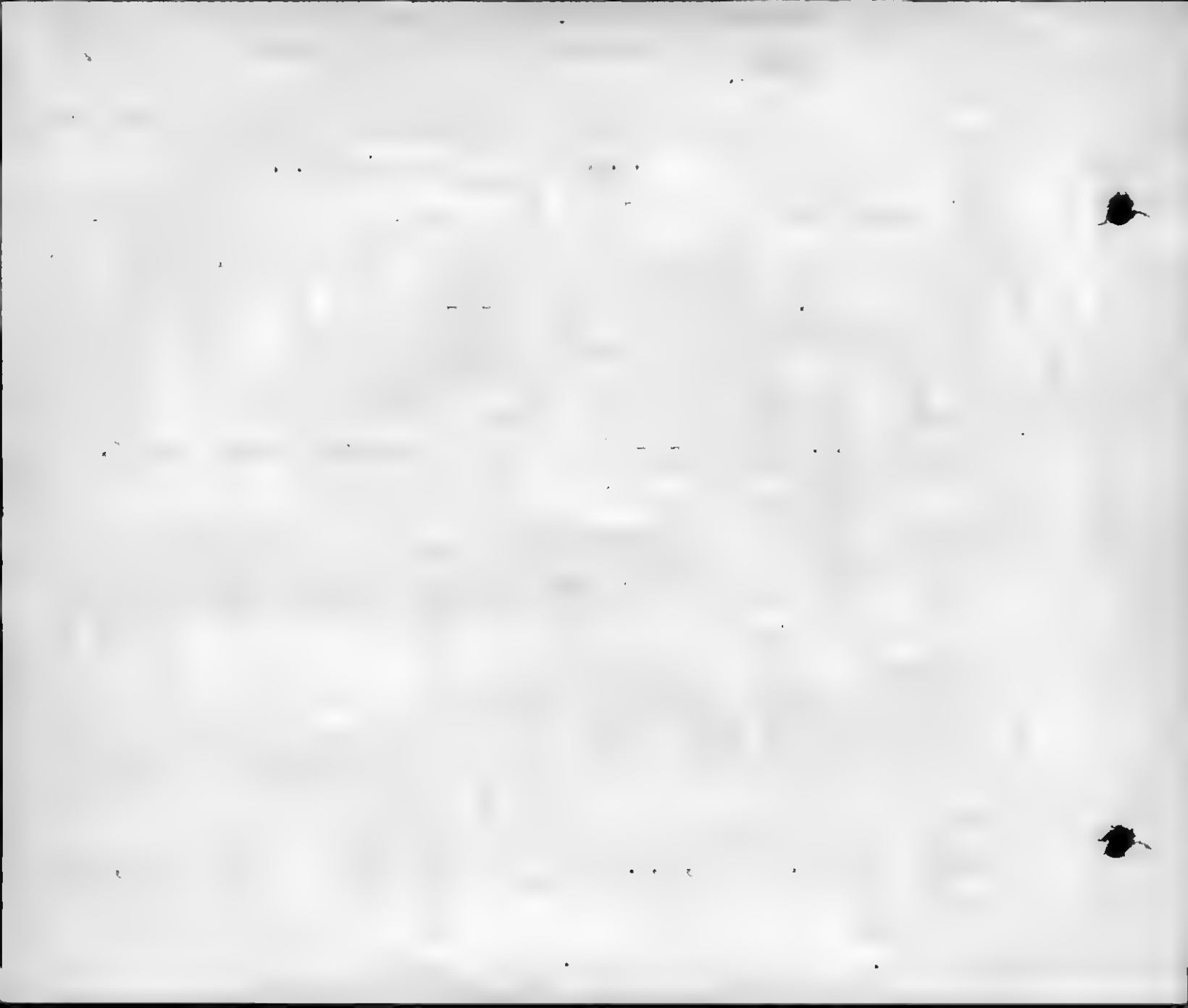
12915

12908

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C. 47x</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				d. STREET ADDRESS <b>1103 50th Place</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James Albert Pinkney</b>				4. DATE OF DEATH Month <b>November</b> Day <b>17</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Col.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-21-1896</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck driver</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Pinkney</b>				14. MOTHER'S MAIDEN NAME <b>Minnie Hawkins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W. 1 579-01-462</b>		17. ADDRESS <b>Beatrice Pinkney; same address as # 2.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Ruptured heart</b> DUE TO (c) <b>Cardiovascular renal disease</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John T. Maloney</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>November 17, 1959</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-20-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Myrtle K. Rollins</b>				24a. REC'D BY REGISTRAR <b>4339 Hunt Pl., N.E.</b>		24b. REGISTRAR'S SIGNATURE <b>DATE NOV 23 '59</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 12 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.



# 1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film G252 11-16-59 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

12916

12948

1. PLACE OF DEATH a. COUNTY <u>Prince Geo.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL & give nearest town) <u>Clinton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Upper Marlboro</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Seaside Hosp Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Martin</u> Middle <u>Herman</u> Last <u>Proctor</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 12th 1883</u>
9. AGE (In years last birthday) yrs <u>75</u>		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>5</u> Hours <u>15</u> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Marcellous Proctor</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth M. Proctor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-01-51789</u>	
17. INFORMANT <u>Daughter, Georgeanna Butler</u>		Address <u>RT #1 Box 278 Upper Marlboro</u>	
18. CAUSE OF DEATH [Enter only one cause for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u> DUE TO (b) <u>Post operative supra-</u> DUE TO (c) <u>bic prostatectomy</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11. 8. 59</u> to <u>11. 8. 59</u> , that I last saw the deceased alive on <u>11. 6</u> , 19 <u>59</u> , and that death occurred at <u>7P</u> M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>A. Samadi</u> M.D.		11. 8. 59.	
PHYSICIAN'S NAME (Type) <u>A. SAMADI</u>		<u>LEONARD TOWN - Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-10-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Roseville Cem</u>		22d. LOCATION (City or town, county, state) <u>Upper Marlboro Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home, Waldorf, Md</u>		24a. REC'D BY REG. STRAR DATE <u>NOV 12 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles E. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

From the  
of the

Received 11-16-29  
from the  
of the

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>15-Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheserh</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover</u>	
c. LENGTH OF STAY IN 1b <u>D.O.G.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen. Hosp.</u>		d. STREET ADDRESS <u>Box 648 - A</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Dorothy Ramsey</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct-25-1939</u>
9. AGE (In years last birthday) yrs. <u>20</u>		IF UNDER 1 YEAR Months <u>22</u> Days <u>27</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Ramsey</u>		14. MOTHER'S MAIDEN NAME <u>Frances Virginia Kuno</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>John Ramsey - same address</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>John J. Maloney</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>November 22, '59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov 24, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 30 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



12908

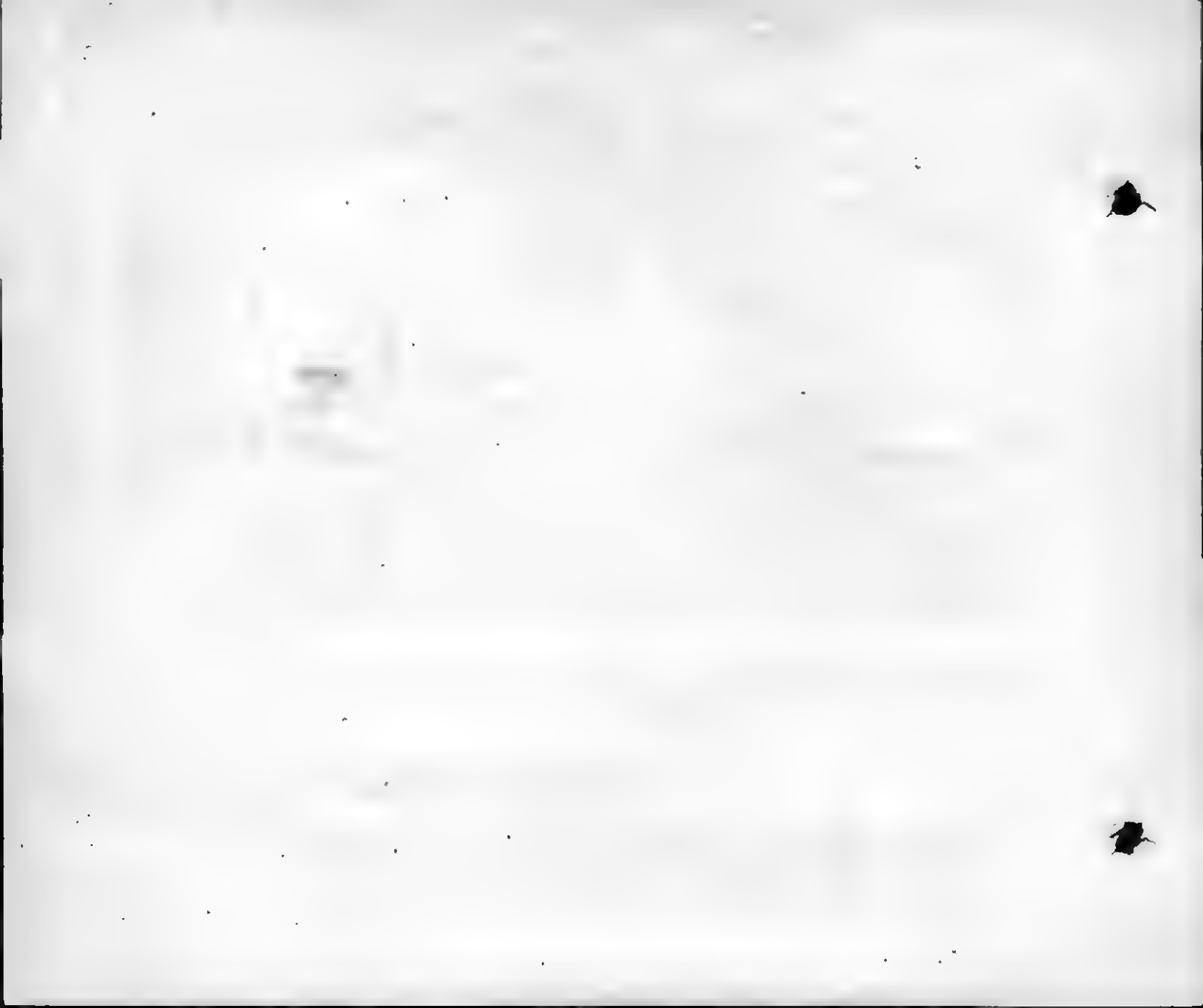
CERTIFICATE OF DEATH

12918

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>0</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Parkway Estates</b> d. STREET ADDRESS <b>4826 67th Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Laura Ann Rasmussen</b>		4. DATE OF DEATH Month Day Year <b>Nov. 8 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 15, 1959</b>
9. AGE (In years last birthday) yrs <b>11</b>		10. IF UNDER 1 YEAR Days Hours Min. <b>11 11 11</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>James Rasmussen</b>		14. MOTHER'S MAIDEN NAME <b>Mary Hince</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <b>none</b>	
INFORMANT <b>Father</b>		Address <b>Same as no 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonitis</b> <b>492X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <b>Nov 8 1959</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cheverly Ave Cheverly Md</b> DATE SIGNED <b>11/14/59</b> ACTUAL SIGNATURE <b>Bertha Van Gelderen</b> PHYSICIAN'S NAME (Type) <b>Bertha Van Gelderen</b> <b>Cheverly, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>nov 12, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>F. Gasch's Sons Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 13 '59</b>	24b. REGISTRAR'S SIGNATURE <b>C. J. ...</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

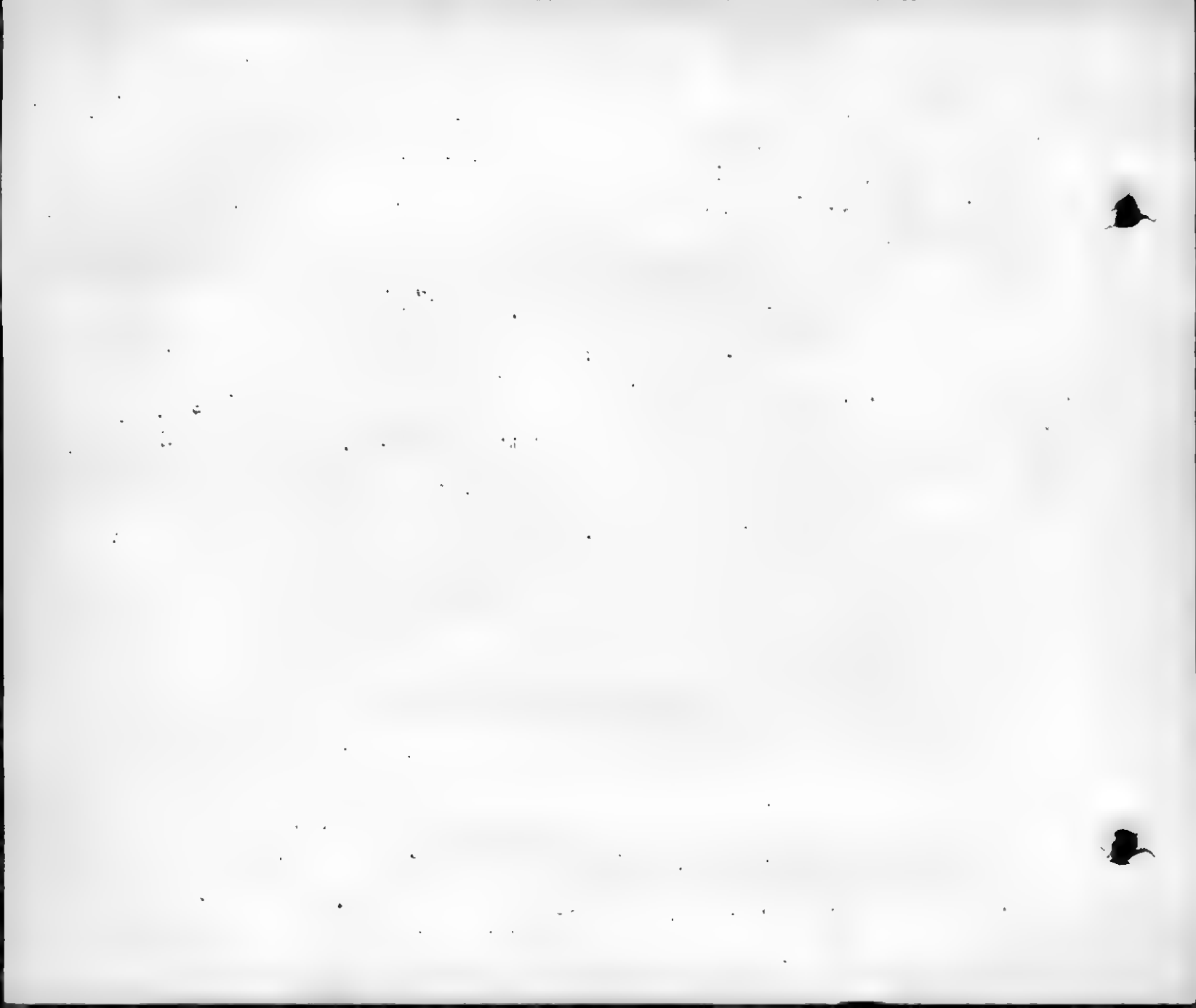
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ISM 9/58

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12857  
CERTIFICATE OF DEATH

12919

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Ohio</u> b. COUNTY <u>Cummt. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. LENGTH OF STAY IN 1b <u>6 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1304 - Legation Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF <u>Mary Dellice</u> First Middle Last (Type or print)		4. DATE OF DEATH Month <u>11</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/12/95</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rel. School Teacher Akron, O.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Thompson, Ohio</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Guernsey H. Whipple</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Richards</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>269-12-7904</u>	
17. INFORMANT <u>1304 Legation Rd</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1551</u> <u>EMANITION &amp; CARDIAC FAILURE</u> DUE TO <u>CARCINOMA COMPTON BILE DUCT</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>WITH METASTASIS</u> DUE TO (c) <u>WITHE METASTASIS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>3 HOURS</u> <u>12 HOURS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>OCT 5, 1957</u> to <u>28 NOV. 1959</u> that I last saw the deceased alive on <u>21 NOV. 1959</u> , and that death occurred at <u>11:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry R. Wolfe</u> M.D.		DATE SIGNED <u>11/28/59</u>	
PHYSICIAN'S NAME (Type) <u>HENRY R. WOLFE, MD</u>		<u>HYATTSVILLE, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Dec 1/59</u>	<u>Mt. Peace</u>	<u>Akron Ohio</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home Inc.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
ADDRESS <u>Mt. Rainier Rd</u>		24a. REC'D BY REGISTRAR <u>DEC 2 '59</u> DATE	



12949

## CERTIFICATE OF DEATH

Reg. Dist. No.

12920

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMP SPRINGS</b> c. LENGTH OF STAY IN IL <b>3 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSP ANDREWS</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>DISTRICT OF COLUMBIA</b> b. COUNTY <b>WASHINGTON D.C.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON D.C.</b> d. STREET ADDRESS <b>2729 TERRACE ROAD SE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DOROTHY</b> Middle <b>M</b> Last <b>SABIN</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>11</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1 November 1931</b>
9. AGE (In years last birthday) <b>28</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
11. BIRTHPLACE (State or foreign country) <b>HARTFORD, WISCONSIN</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ALTIA I. RUBY</b>		14. MOTHER'S MAIDEN NAME <b>OLIVE BREWBAKER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>508-34-6302</b>	
17. INFORMANT <b>ROBERT C SABIN (II)</b>		Address <b>2729 Terrace Road Se, Washington 20, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>pulmonary edema</b> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Breast carcinoma metastatic to the lung.</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH 4 1/2 years</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9 NOVEMBER</b> , 19 <b>59</b> , to <b>11 NOVEMBER</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11 NOVEMBER</b> , 19 <b>59</b> , and that death occurred at <b>10:19 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>DATE SIGNED</b>			
ACTUAL SIGNATURE <b>Murray P. Shevick</b> M.D.		USAF HOSP ANDREWS, ANDREWS AFB, WASH 25 DC	
PHYSICIAN'S NAME (Type) <b>MURRAY P. SHEVICK CAPT USAF MC</b>		USAF HOSP ANDREWS, ANDREWS AFB, WASH 25 DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		22b. DATE THEREOF <b>11-12-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>LEE'S CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. J. Riebel</b> ADDRESS <b>816 H ST. N.E. WASH 2, D.C.</b>		24a. REC'D BY REGISTRAR <b>DATE NOV 13 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12921

12909

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cherry		c. LENGTH OF STAY IN 1b 2 Wks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges Gen Hosp		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cherry	
3. NAME OF DECEASED (Type or print) First Middle Last Arthur Charles Schalk		4. DATE OF DEATH Month Day Year Nov 14 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10 1896 63 yrs.
9. AGE (in years last birthday) 63		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, when it retired) Special Police - U.S. Govt		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Schalk		14. MOTHER'S MAIDEN NAME Margaret Wentz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W-4-1	
17. INFORMANT Ethel Schalk - Home address #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO (b) Cardiovascular renal disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John J. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JOHN T. MALONEY - M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/18/59	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE		24. REC'D BY REGISTRAR	
Nalley's Funeral Home		DATE NOV 18 1959	
ADDRESS Mt. Rainier		24b. REGISTRAR'S SIGNATURE	
Dne.		John S. Hines	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

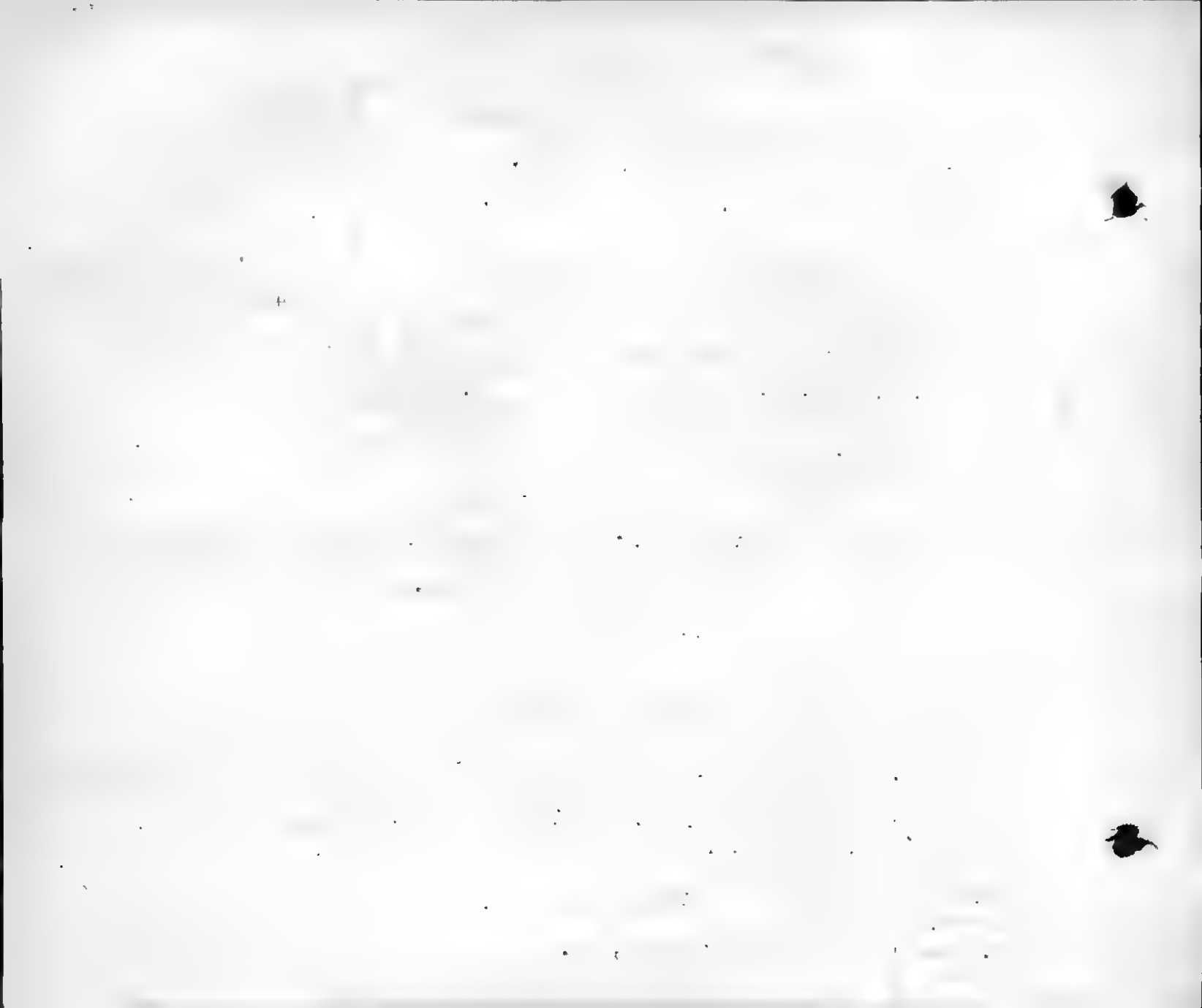


1  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 Item 9 Film G251 11-10-59 et  
 12910 CERTIFICATE OF DEATH

12922

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>1 Day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Eunice</b> Middle <b>E</b> Last <b>Shaver</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>1</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/18/08</b>
9. AGE (In years last birthday) <b>50</b> yrs.		10. IF UNDER 1 YEAR Months <b>49</b> Days <b>49</b> Hours <b>49</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>A. M. Mc Comas</b>		14. MOTHER'S MAIDEN NAME <b>Vesta Nelson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>Unk</b>	
17. INFORMANT <b>Delbert E Shaver</b>		Address <b>Hyattsville Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>410X Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Mitral Stenosis &amp; Patent Foramen Ovale</b> DUE TO (c) <b>Chronic Rheumatic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Pulmonary Emphysema due to Chronic Bronchitis</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>56</b> to <b>Nov. 1</b> , 19 <b>59</b> that I last saw the deceased alive on <b>November 1</b> , 19 <b>59</b> , and that death occurred at <b>1:25 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William D. Rosson M.D.</b>		ADDRESS (Street, city or town, state) <b>5304 Annapolis Road</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Rosson, M.D.</b>		DATE SIGNED <b>Bladensburg, Maryland</b>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/5/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Kessler Funeral Home</b>		22d. LOCATION (City, town, or county) <b>Akron Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
24a. REC'D BY REGISTRAR <b>NOV 5 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

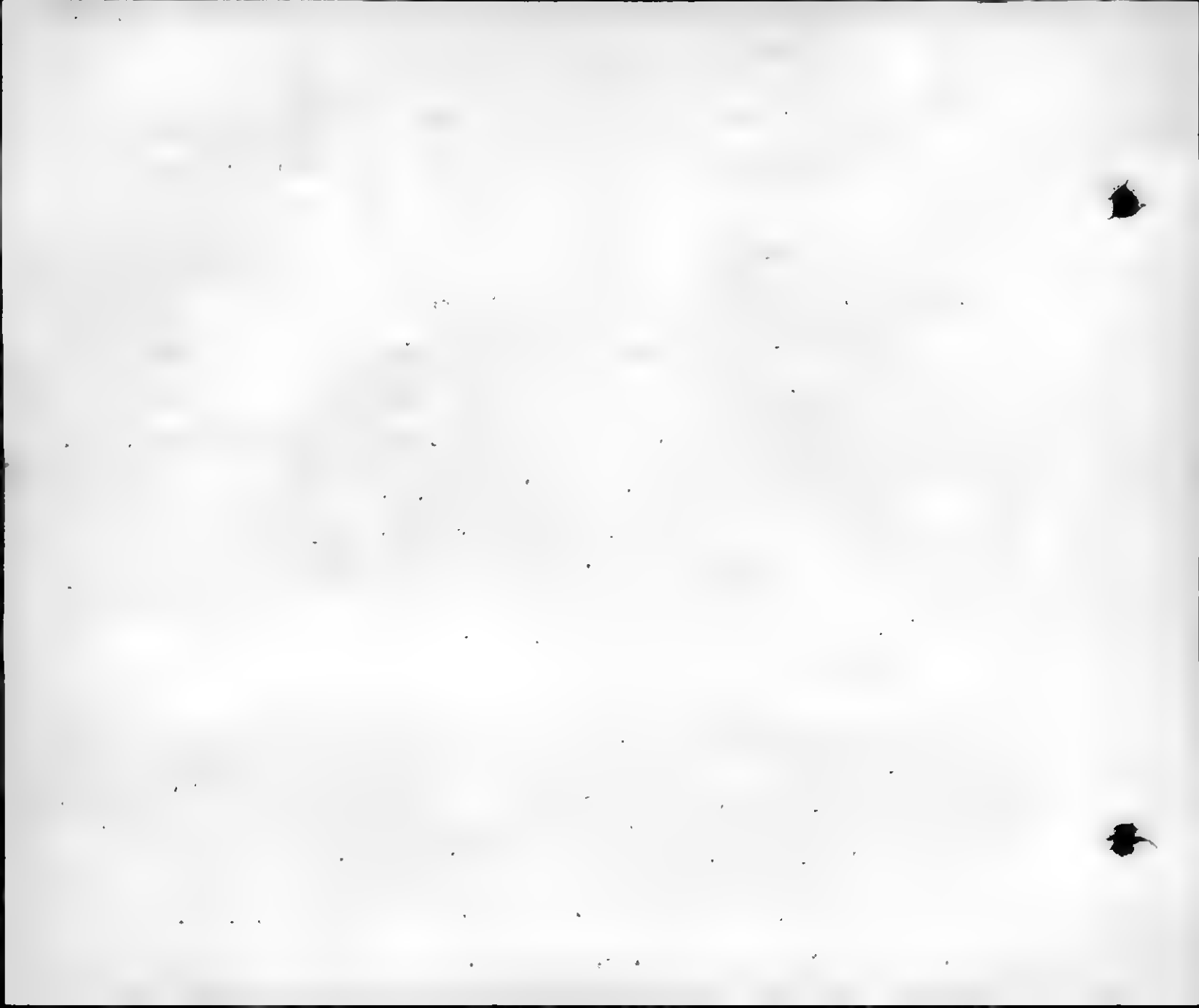
12923

12950

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Berwyn Heights Md</b>		c. LENGTH OF STAY IN lb <b>40 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8515 60th Place</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Berwyn Heights, Md.</b>	
f. STREET ADDRESS <b>8515 60th Place</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>Smith</b> Last <b>Smith</b>		4. DATE OF DEATH Month <b>November</b> Day <b>25</b> Year <b>19 59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 30, 1873</b>
9. AGE (In years last birthday) <b>86 yrs.</b>		10. IF UNDER 1 YEAR Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min. <b>86</b>	11. IF UNDER 24 HRS. Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min. <b>86</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>? Clodgett</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Paul J Mc Cullough</b>		Address <b>Berwyn Heights, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Arteriosclerosis</b> DUE TO <b>Chronic Arteriosclerosis</b> (c) <b>Chronic Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myocardial Infarction</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 25, 1959</b> to <b>Nov 25, 1959</b> , and that death occurred at <b>Nov 25, 1959</b> , from the causes and on the date stated above.		22. ADDRESS (Street, city or town, state) <b>Berwyn, Md.</b>	
ACTUAL SIGNATURE <b>Robert C Wingfield</b>		DATE SIGNED <b>Nov 25, 1959</b>	
PHYSICIAN'S NAME (Type) <b>Robert C Wingfield</b>		<b>Laurel, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 28, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Maryland.</b>	
24a. REC'D BY REGISTRAR <b>NOV 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>C. J. L. H. H.</b>	



## CERTIFICATE OF DEATH

12924

Reg. Dist. No.

12951

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>4</b> b. COUNTY <b>4</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Friendly, Md. (Rural)</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>			
c. LENGTH OF STAY IN TB <b>11 days</b>				d. STREET ADDRESS <b>224 Second St. N.E.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8320 Old Fort Rd S.E.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Eugenia</b> Middle <b>Smith</b> Last <b>Smith</b>				4. DATE OF DEATH Month <b>NOV.</b> Day <b>4</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>APR. 30 1876</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>3</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Post Office (Retired)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Chicago, Ill.</b>			
11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Arthur E. Carter</b>				14. MOTHER'S MAIDEN NAME <b>Sarah E. Allen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>Murray</b>		17. INFORMANT <b>Marie E. Murray</b> Address <b>3500 Savannah St. S.E.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Degeneration</b> <b>420.0</b> DUE TO							<b>1 month</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							(b) <b>Arterio-sclerotic Heart Disease</b> DUE TO <b>3 yrs.</b>
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> Month, Day, Year				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>Nov. 2, 1959</b> to <b>Nov. 4, 1959</b> , that I last saw the deceased alive on <b>Nov. 4, 1959</b> , and that death occurred at <b>6:15 PM</b> , from the causes and on the date stated above							DATE SIGNED
ACTUAL SIGNATURE <b>Anna Coyne Todd</b>				M.D. <b>7519 Broadview Rd S.E.</b> <b>11/4/59</b>			
PHYSICIAN'S NAME (Type) <b>ANNA COYNE TODD</b>				<b>Friendly, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-9-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Chicago, Illinois</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. R. ...</b> ADDRESS <b>3015-12th St N.E. Washington D.C.</b>				24a. REC'D BY REGISTRAR <b>NOV 9 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. ...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



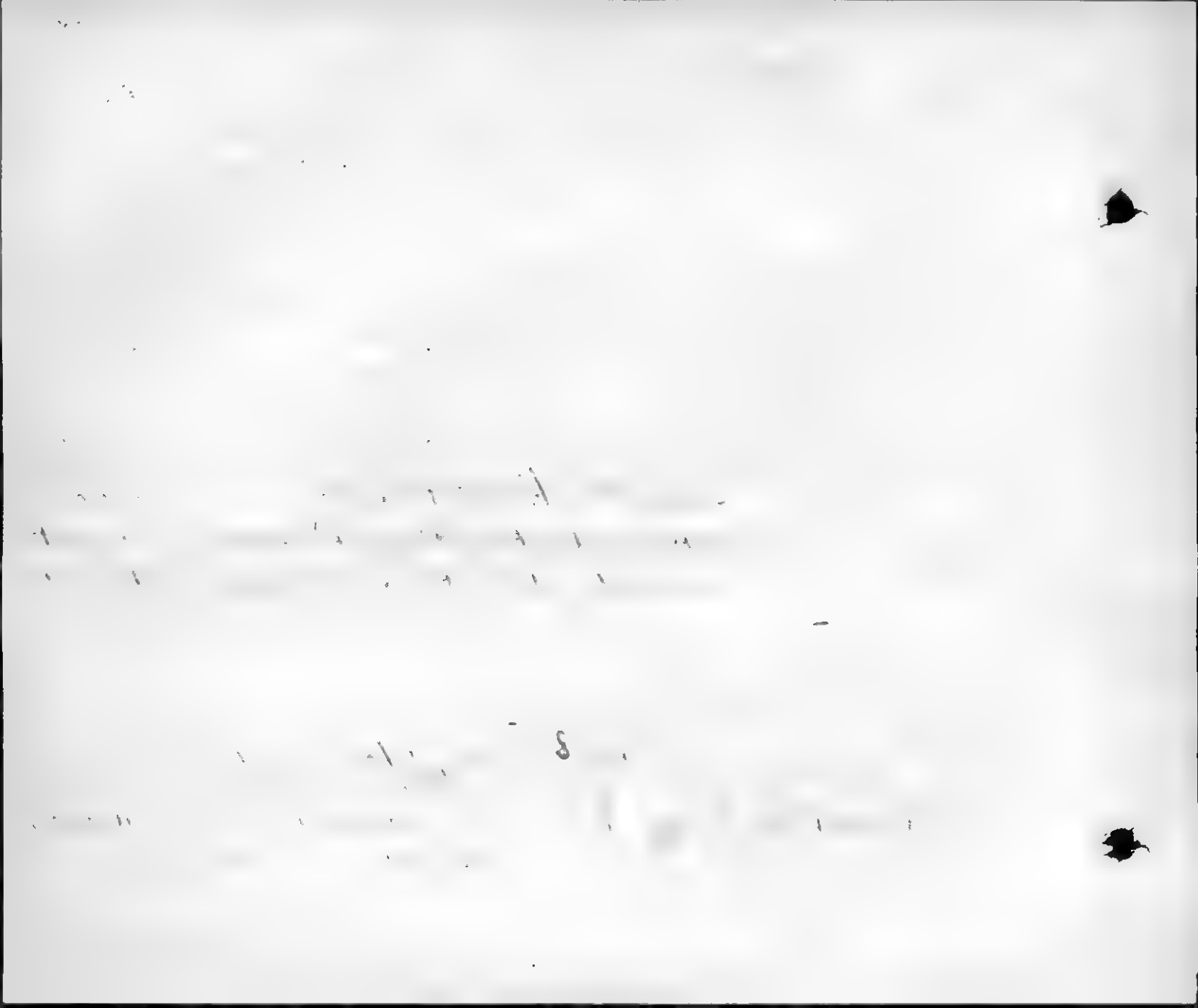
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE District b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Adair's Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. 47X-3	
3. NAME OF DECEASED (Type or print) Levy Newton Stely		4. DATE OF DEATH Nov 21 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 13, 1909
9. AGE (In years last birthday) 51		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY 1. no	
11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, (If yes, give war or dates of service)) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Phillip S. Ar. ke		Address 4700 ...	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Congestive Heart Failure (b) Arteriosclerotic Heart Disease (c) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO 2 yrs + 10 yrs +			INTERVAL BETWEEN ONSET AND DEATH 2 wks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1958 to 11/20 1959, that I last saw the deceased alive on 11/20 1959, and that death occurred at 935 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank M. Trozzo		DATE SIGNED 11/21/59	
PHYSICIAN'S NAME (Type) FRANK M. TROZZO		ADDRESS (Street, city or town, state) 3501 Hamilton St Hyattsville, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/24/59	22c. NAME OF CEMETERY OR CREMATORY Flint Hill Cem.	22d. LOCATION (City, town, or county) (State) Oakton, Va.
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		ADDRESS 4th & ...	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur S. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12912

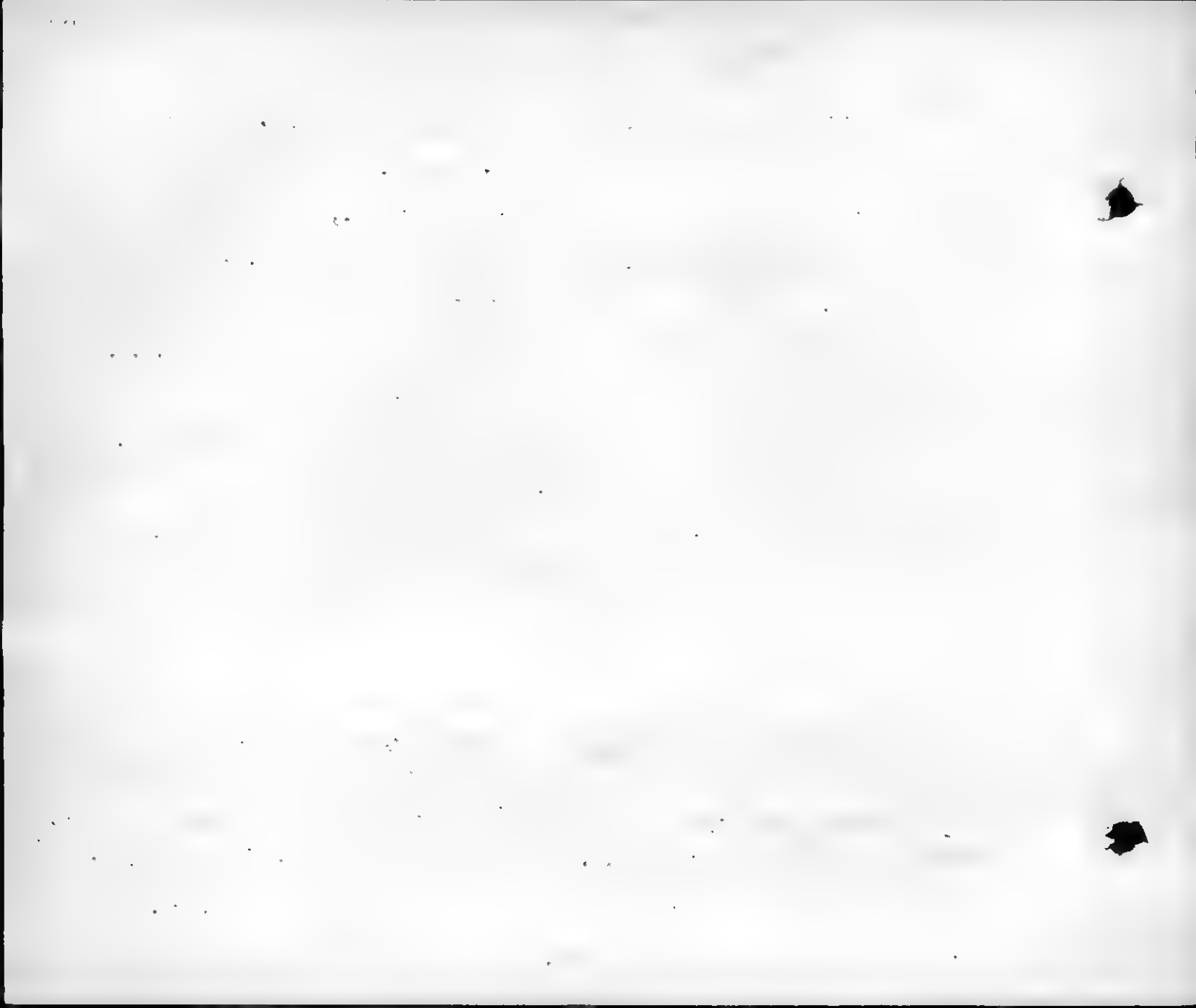
## CERTIFICATE OF DEATH

12926

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>6 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>E. Riverdale</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>				d. STREET ADDRESS <u>5423 55th Pl.</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Valencia</u> Middle <u>Stewart</u> Last <u></u>				<b>4. DATE OF DEATH</b> Month <u>Nov</u> Day <u>3</u> Year <u>19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-21-33</u>		9. AGE (In years last birthday) <u>27</u> yrs	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arthur C Krites</u>				14. MOTHER'S MAIDEN NAME <u>Zora V Swisher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknowns) <u>no</u>		16. SOCIAL SECURITY NO. <u>577 42 6474</u>		INFORMANT <u>Robert C Stewart</u> Address <u>E Riverdale, Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary edema</u> DUE TO (b) <u>Decm pregnancy &amp; Caesarian section.</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/7</u> , 19 <u>59</u> , to <u>11/3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/3</u> , 19 <u>59</u> , and that death occurred at <u>11:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Julius Kauffman</u> M.D.				ADDRESS (Street, city or town, state) <u>5102 Annapolis Rd. Bladensburg, Md.</u> DATE SIGNED <u>11/4/59</u>			
PHYSICIAN'S NAME (Type) <u>Dr Julius Kauffman, M.D.</u>				<u>5102 Annapolis Rd. Bladensburg, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL. (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/7/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 10 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
TSM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

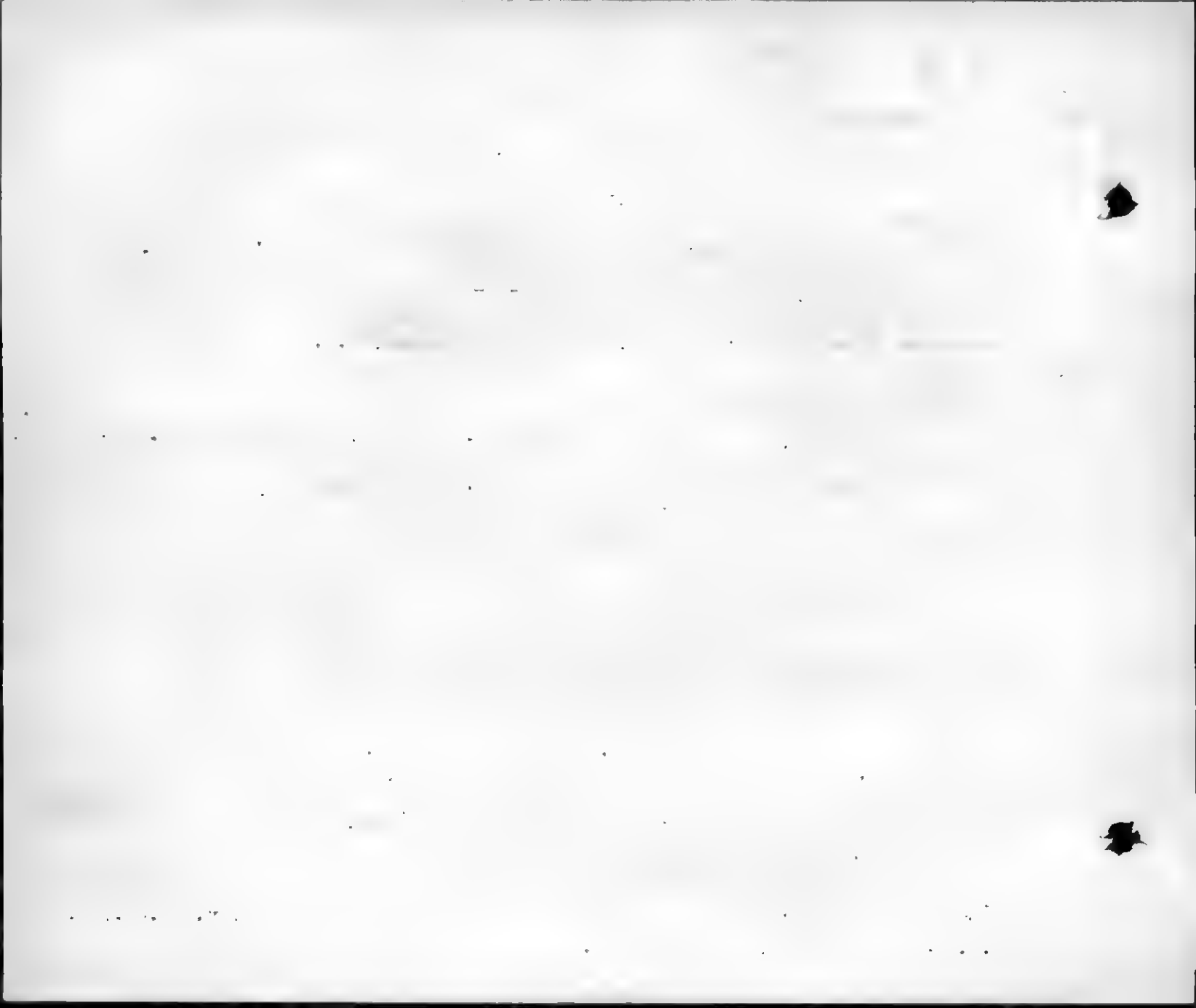
12913

CERTIFICATE OF DEATH

Reg. Dist. No.

12927

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesley</b>		c. LENGTH OF STAY IN 1b <b>2 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Leroy</b> Middle <b>Andrew</b> Last <b>Stickley</b>		4. DATE OF DEATH <b>Nov.</b> Month <b>20</b> Day <b>19</b> Year <b>59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-12-05</b>
9. AGE (In years last birthday) <b>54</b> yrs		10. IF UNDER 1 YEAR Months <b>54</b> Days <b>19</b> Hours <b>59</b> Min.	11. IF UNDER 24 HRS. Months <b>54</b> Days <b>19</b> Hours <b>59</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inspector of Materials</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US Weapons Center</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Gabriel Stickley</b>		14. MOTHER'S MAIDEN NAME <b>Ida Adams</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>Peacetime</b>		16. SOCIAL SECURITY NO. <b>None</b>	
INFORMANT <b>Agnes L. Stickley</b>		Address <b>4017 Madison St. Hyattsville, Md.</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Emphysema of the lungs with severe fatty degeneration,</b> DUE TO (b) <b>Emphysema of the lungs with severe fatty degeneration,</b> DUE TO (c) <b>Emphysema of the lungs with severe fatty degeneration,</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour <b>10</b> a. m. <b>10</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 18</b> , 19 <b>59</b> , to <b>Nov. 20</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Nov. 20</b> , 19 <b>59</b> , and that death occurred at <b>10:10 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Ronald S. Fleischer</b>		ADDRESS (Street, city or town, state) <b>5932 Queens Chapel Rd</b>	
PHYSICIAN'S NAME (Type) <b>RONALD S. FLEISCHER</b>		DATE SIGNED <b>11/29/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/23/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Pr. Geo. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Company, Riverdale, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 24 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **12928**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Prince Geo.</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>			c. LENGTH OF STAY IN 1b <b>2 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>352 Main Street</b>				d. STREET ADDRESS <b>352 Main Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Wilhelmine</b> Middle <b>Reinhilde</b> Last <b>Stumpf</b>				<b>4. DATE OF DEATH</b> Month <b>November</b> Day <b>11</b> Year <b>19 59</b>			
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>white</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>5-14-12</b>	
<b>9. AGE</b> (In years last birthday) <b>47</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Months Days Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (State or foreign country) <b>Germany</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>Germany</i>	
<b>13. FATHER'S NAME</b> <b>Ferdinand Hammer</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Marie Kempf</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> (If yes, give war or dates of service)		<b>17. INFORMANT</b> Address <b>Karl Stumpf; same address</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH
<b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <b>Spontaneous intracerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral hypertension</b> DUE TO (c)							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>Cardiovascular renal disease</b>							<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>							
<b>ACTUAL SIGNATURE</b> <i>John T. Maloney</i> M.D.				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b>	
<b>EXAMINER'S NAME (Type)</b> <b>John T. Maloney, M.D.</b>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>11/14/59</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Canner Memorial Park</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Mount Airy Md</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <i>Dr. W. T. Donaldson Laurel Md</i>				<b>24a. REC'D BY REGISTRAR</b> DATE <b>NOV 18 '59</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur L. Frank</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

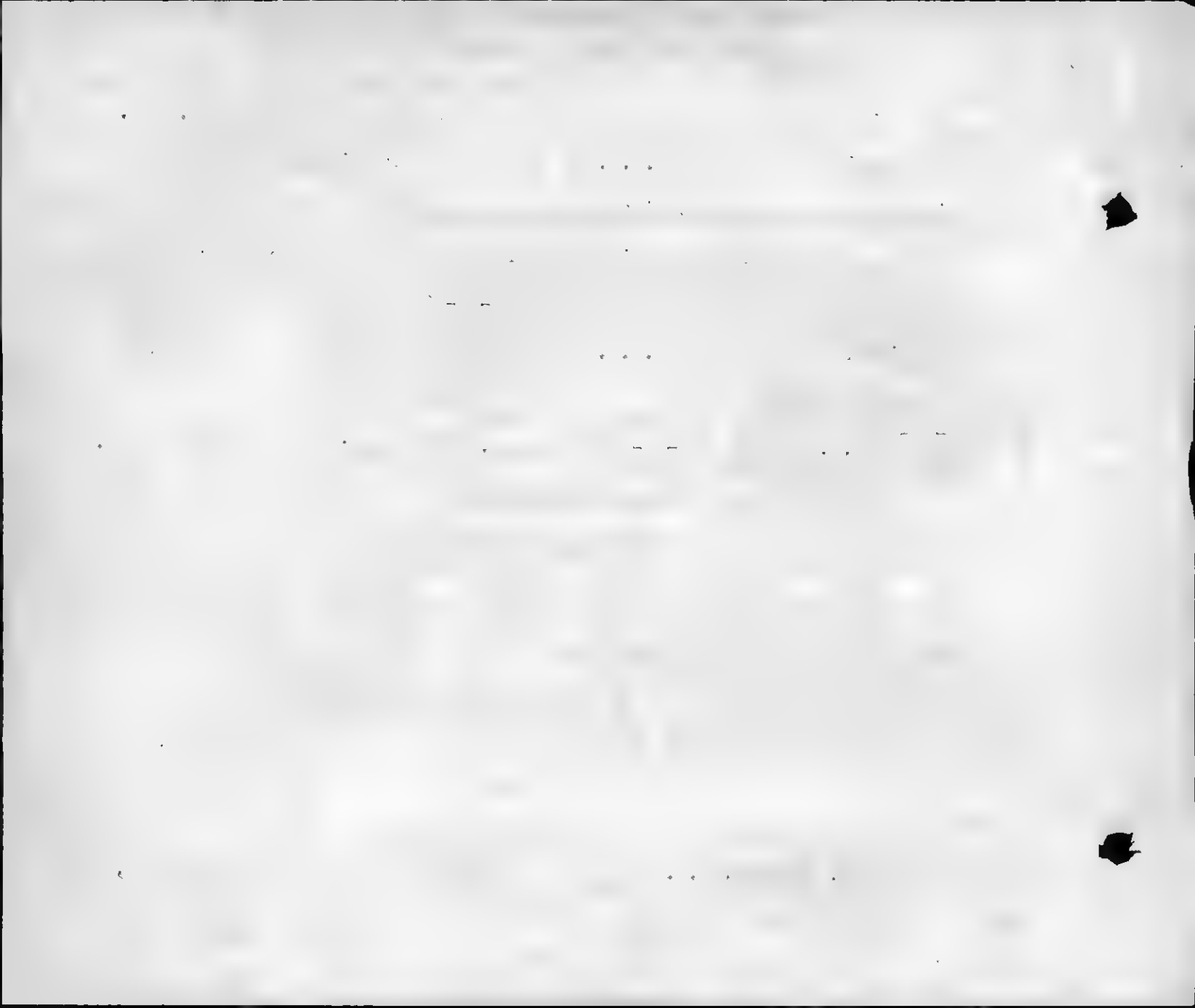
Reg. Dist. No.

14187

12915

<b>1. PLACE OF DEATH</b> COUNTY <u>Prince Georges</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X <u>Landover Hills</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>6835 Annapolis Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Alexander</u> Middle <u>Francis</u> Last <u>Sutherland</u>				<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>23</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>3-26-13</u>		9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book binder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>G.P.O.</u>		11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Walter Sutherland</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Fey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or if yes, give war or dates of service) <u>Yes 803-91-61 U.S. Navy</u>				16. SOCIAL SECURITY NO. <u>011-09-5876</u>			
17. INFORMANT <u>Ruth E. Sutherland; same address as # 2.</u>				Address			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral compression</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Intracerebral hemorrhage</u> (a), stating the underlying cause last, DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John T. Maloney</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>November 23, 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transportation 11/24/59</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Conway Funeral Home</u>			
22d. LOCATION (City, town, or county) <u>Peabody</u>		(State) <u>Massachusetts</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>			
24a. REC'D BY REGISTRAR <u>NOV 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, and page 4 with the registrar, cremation, or removal.



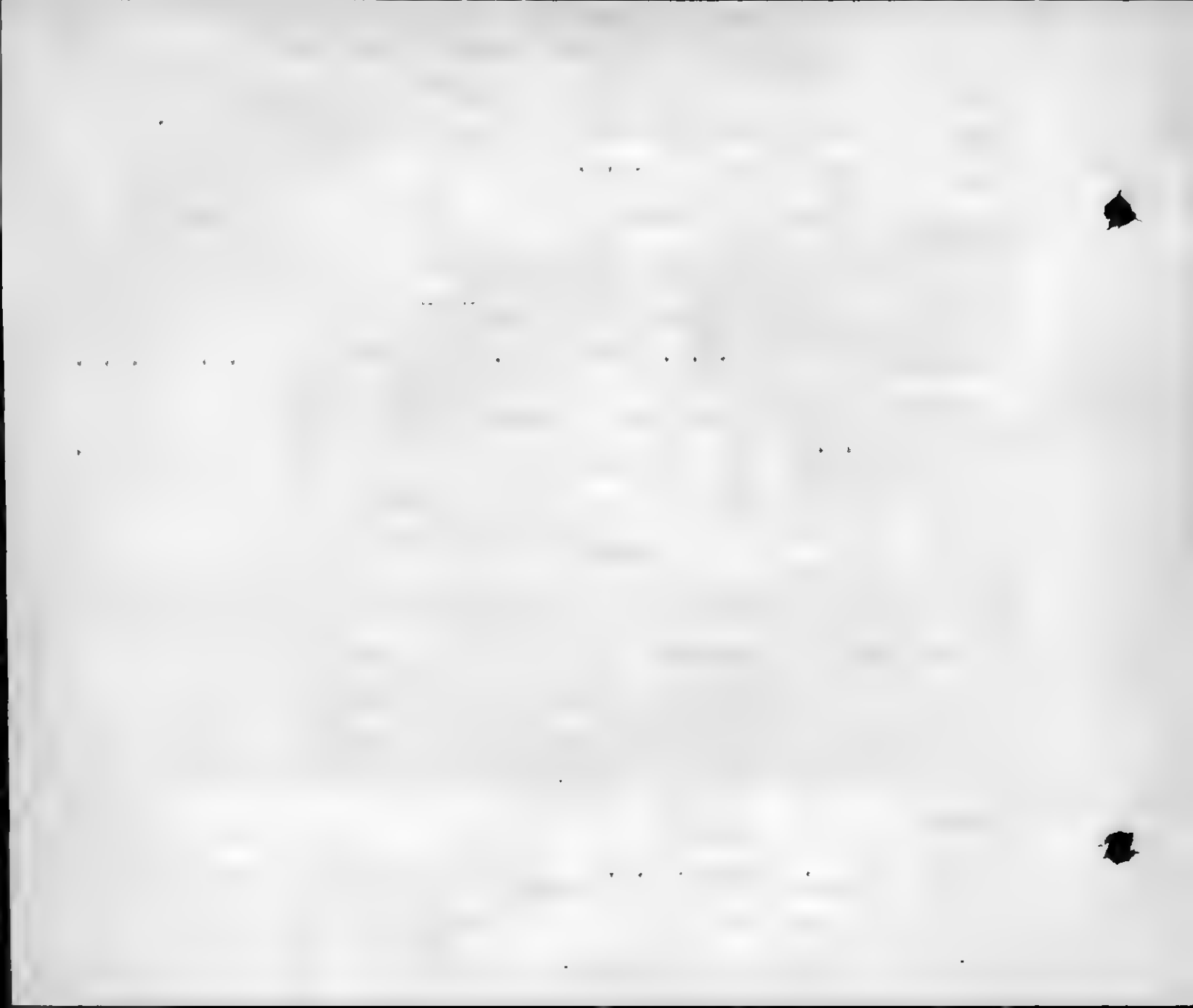
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. **12929**

**12916**

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN Ib <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>University Park</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>				f. STREET ADDRESS <b>6509 Colesville Road</b>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Arthur</b> Last <b>Taylor</b>				4. DATE OF DEATH Month <b>November</b> Day <b>9</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-19-13</b>	
9. AGE (In years last birthday) <b>46</b> yrs.		10. IF UNDER 1 YEAR Months <b></b> Days <b></b>		11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>G.P.O. Field Serv.</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Taylor</b>				14. MOTHER'S MAIDEN NAME <b>Nellie Padgett</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.E. 2</b>		17. INFORMANT Address <b>Cicelia Taylor; same address as # 2.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary and cerebral edema</b> <b>4341</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Acute congestive heart failure</b> (c) <b></b> DUE TO cause last, stating the underlying cause lost, (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b></b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John T. Maloney</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>November 10, 1959</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 13, 1959</b>		22c. NAME OF CEMETERY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Va</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 16 59</b> DATE	
				24b. REGISTRAR'S SIGNATURE <b>C. J. &amp; L. Hanna</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form IM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar or to burial, cremation, or removal.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12917

## CERTIFICATE OF DEATH

Reg. Dist. No.

12930

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 Riverdale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Edward Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First <u>Gertrude</u> Middle <u>Elizabeth</u> Last <u>Troy</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>Fem</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 15, 1877</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Wash., D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Augustus Berkeley</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Horstham</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT <u>Son, John A. Troy</u> Address <u>854 N. Lebanon Arlington, VA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Intestinal Obstruction</u> <u>570.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Mesenteric Thrombosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Oct 29, 1959</u> , to <u>Nov. 1, 1959</u> , that I last saw the deceased alive on <u>Nov 1, 1959</u> , and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theo Zegarra, M.D.</u> M.D. <u>4408 Queen Lane Rd</u>				ADDRESS (Street, city or town, state) <u>Prince George, Md.</u>			
DATE SIGNED <u>11-1-59</u>							
PHYSICIAN'S NAME (Type) <u>Theodore Zegarra, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 4, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN</u>		22d. LOCATION (City, town, or county) (State) <u>Pr Geo Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers &amp; Co</u> ADDRESS <u>5801 Cleveland Ave Riverdale, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Howard</u>	



12918

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b> c. LENGTH OF STAY IN 1b <b>5 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Beland Memorial Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b> d. STREET ADDRESS <b>16202 Carrollton Terrace</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <b>Ann Elizabeth Turner</b>		4. DATE OF DEATH <b>11 - 26 - 1959</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-6-91 1880</b>		9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Fun Home</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Horace A. Harrison</b>				14. MOTHER'S MAIDEN NAME <b>Julia Athey</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>				16. SOCIAL SECURITY NO <b>✓</b>				17. INFORMANT <b>Hospital Record (Miss Eunice Turner) Daughter</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Edema of brain</b> DUE TO <b>Carcinoma (adenos) of Stomach</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>lycan</b> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <b>2-3 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)															
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>11-30</b> , 1959, to <b>11-26</b> , 1959, that I last saw the deceased alive on <b>11/30</b> , 1959, and that death occurred at <b>4:30</b> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Riverdale Md</b> DATE SIGNED <b>Nov 26, 1959</b>																			
ACTUAL SIGNATURE <b>R. Wilkinson</b>				M.D. <b>Riverdale Md.</b>				PHYSICIAN'S NAME (Type) <b>R Wilkinson</b>				Riverdale Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Nov 28, 1959</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Burtonsville, Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>								ADDRESS <b>Hyattsville, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 30 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

12919

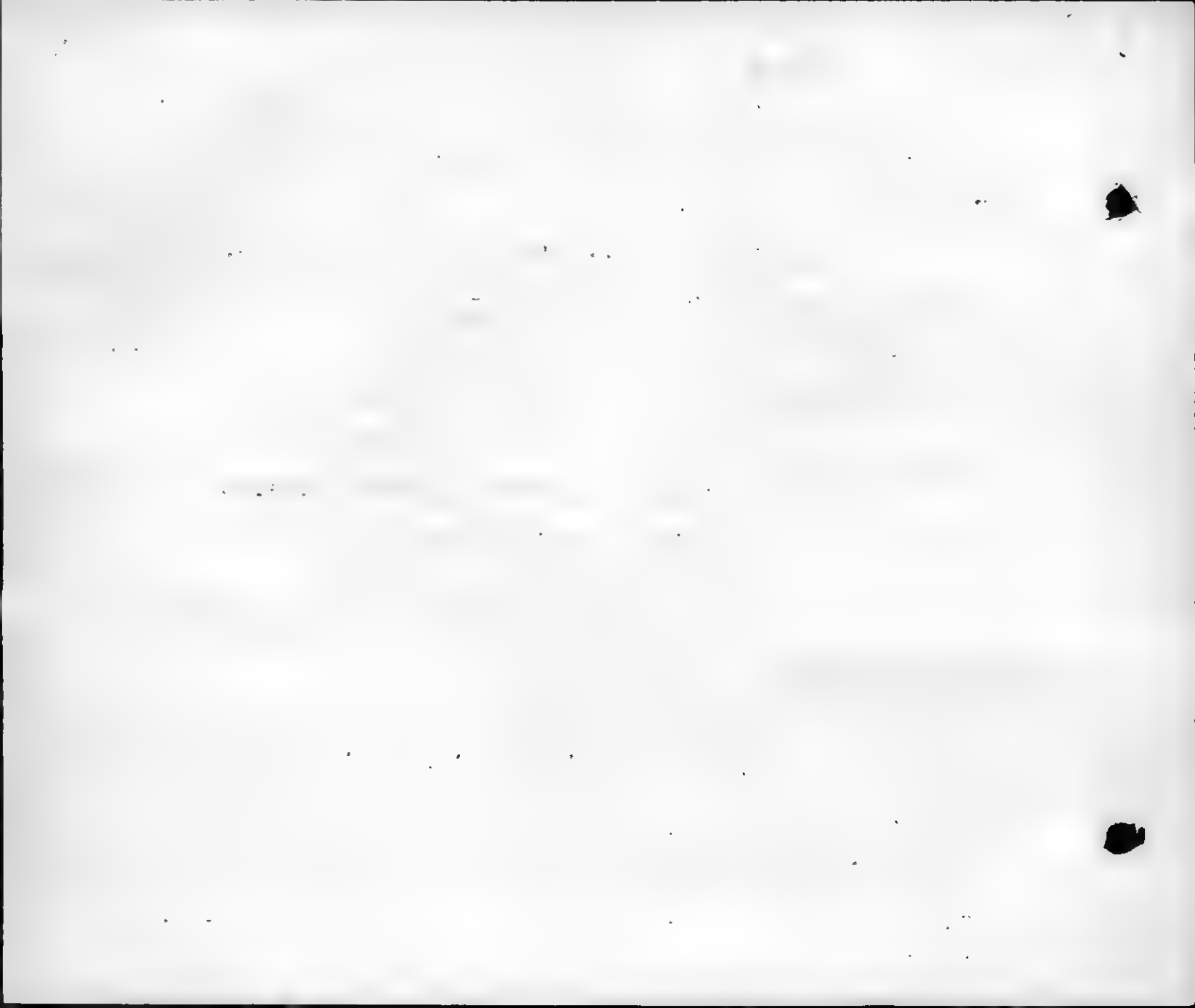
1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>12 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>A.</b> Last <b>VanHorn</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>3</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-13-79</b>
9. AGE (In years last birthday) <b>80</b>		10. IF UNDER 1 YEAR Months <b>80</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Lowther</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Burton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Gladys Eubank-daughter-same as 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis(Left internal Capsule)</b>			
332X DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
(b) <b>Cerebral Arteriosclerosis</b> DUE TO			
(c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 22, 19 59</b> to <b>Nov. 3, 19 59</b> , that I last saw the deceased alive on <b>Nov. 3, 19 59</b> , and that death occurred at <b>1:25 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John M. Grassgreen</b>		ADDRESS (Street, city or town, state) <b>3101 ARUNDEL RD.</b>	
DATE SIGNED <b>MT. RAINIER MD</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Grassgreen</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit 11/6/59</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Grove Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Doddridge Co. W. Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey</b>		24a. REC'D BY REGISTRAR <b>NOV 5 '59</b>	
ADDRESS <b>Bethesda, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

1

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12920

## CERTIFICATE OF DEATH

Reg. Dist. No.

12934

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Brentwood				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4 North Brentwood			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4506 41st Avenue				d. STREET ADDRESS 4506 41st Avenue			
3. NAME OF DECEASED (Type or print) First Middle Last Martha J. Wallace				4. DATE OF DEATH Month Day Year 11/9/59 19			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/28/1874	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Otha Johnson			
14. MOTHER'S MAIDEN NAME Elizabeth --				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Mrs. Otelia Muggs 1207 48th St., N. E., D. C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 11, 1959, to Nov 9, 1959, that I last saw the deceased alive on Nov 9, 1959, and that death occurred at M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Leonard Hays				ADDRESS (Street, city or town, state) 5201 Balto. Ave., Hyattsville, Maryland			
PHYSICIAN'S NAME (Type) Leonard Hays				DATE SIGNED M.D. Hyattsville, Md. 11-1-59			
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF 11/13/59		22c. NAME OF CEMETERY OR CREMATORY Carver Memorial Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges Co., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert M. Hays				ADDRESS 1820 St. Paul St. Wash. DC		24a. REC'D BY REGISTRAR DATE NOV 12 '59	
				24b. REGISTRAR'S SIGNATURE C. S. Hays			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

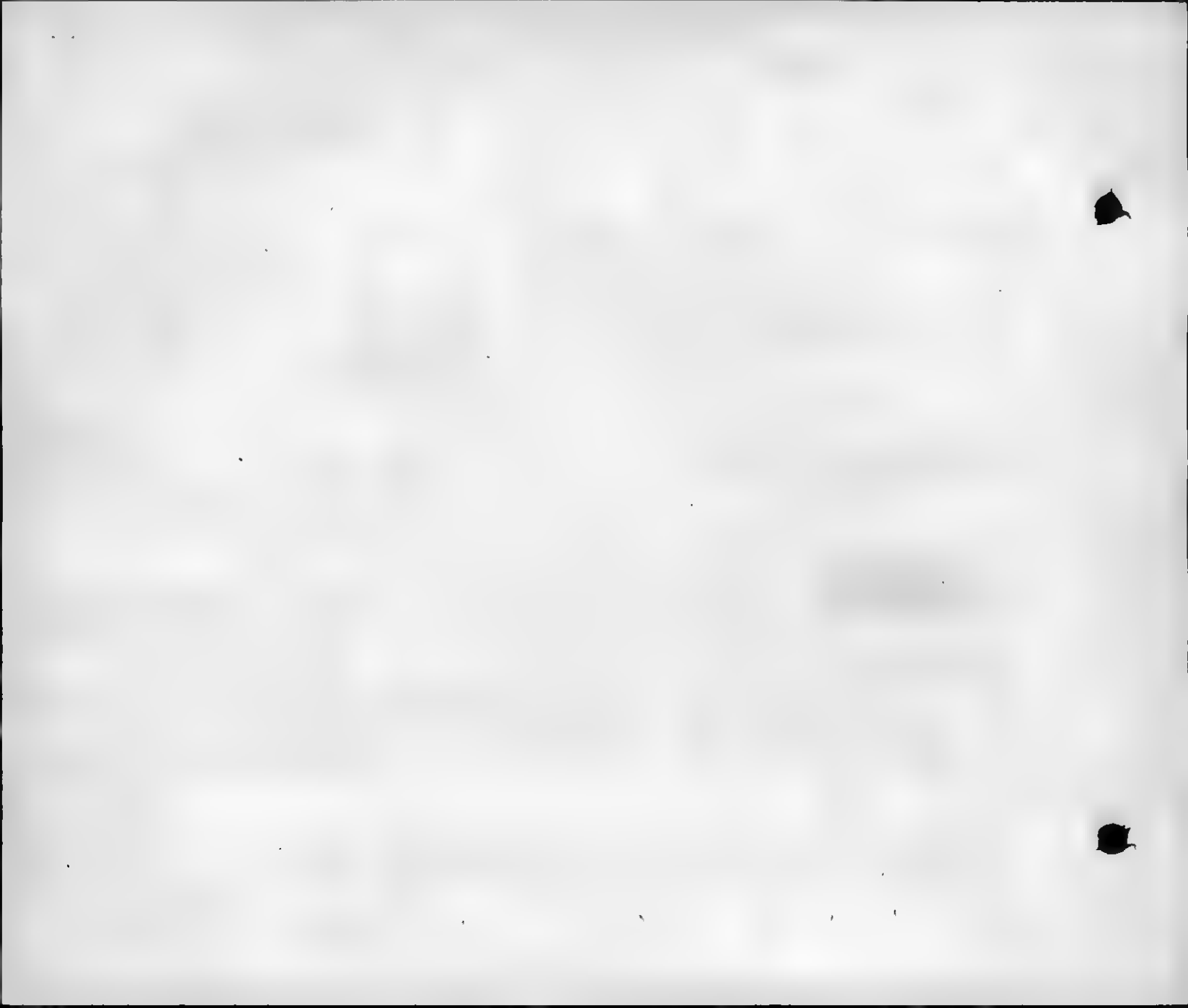
12935

Reg. Dist. No.

12921

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pi. Geo</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. LENGTH OF STAY IN lb <u>209</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairmount Heights</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen Hosp</u>			d. STREET ADDRESS <u>6107- R. Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Eula Mae White</u>			4. DATE OF DEATH Month <u>11</u> Day <u>6</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-16-1918</u>		9. AGE (In years last birthday) <u>41</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tobacco farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tobacco</u>		11. BIRTHPLACE (State or foreign country) <u>S. Carolina</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Ben Walters</u>			14. MOTHER'S MAIDEN NAME <u>Cinnabelle Watson</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO		17. INFORMANT Address <u>Clarence Young, 6107 R. St., Wt.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gente congestive heart failure</u> 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hepatic failure</u> (a), stating the underlying cause last. (c) <u>Cirrhosis of the liver</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Washington, D.C.</u>	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John J. Maloney</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Nov-7-1959</u>	
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11-10-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN</u>		22d. LOCATION (City, town, or county) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Rhinehart &amp; Co. 3015-12th St</u>		ADDRESS <u>Washington D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 12 '59</u>	24b. REGISTRAR'S SIGNATURE <u>John S. Rhinehart</u>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

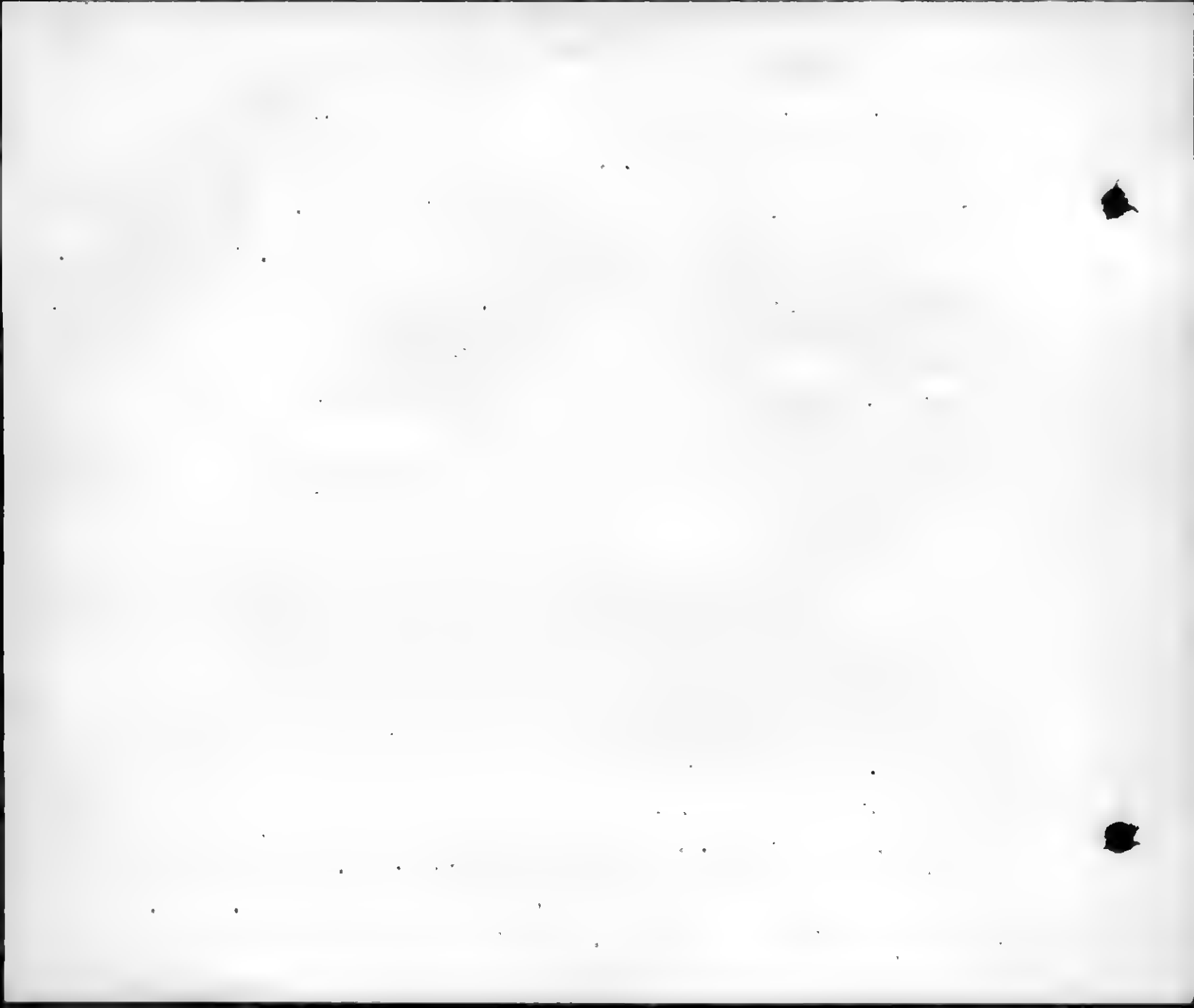
Reg. Dist. No.

12936

12922

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Arden	
c. LENGTH OF STAY IN lb 30 Min.		d. STREET ADDRESS 7828 Piedmont Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Baby Girl Williams		4. DATE OF DEATH Month Day Year Nov. 3, 1959	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1959
9. AGE (In years lost birthday) yrs. 30		10. IF UNDER 1 YEAR Months Days Hours Min 30	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Ernest J. Williams		14. MOTHER'S MAIDEN NAME Florence Clayborne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO Mother	
17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day, Year Hour o m p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 3, 1959, to Nov. 3, 1959, that I last saw the deceased alive on Nov. 3, 1959, and that death occurred at 6:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. John Perkins M.D.		DATE SIGNED 11/4/59	
PHYSICIAN'S NAME (Type) 5301 Hamilton St. Hyattsville		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMAINS (Specify) CREMATION		22b. DATE THEREOF 11/9/59	
22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr. Administrator.		24a. REC'D BY REGISTRAR DATE NOV 13 '59	
24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE	

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## CERTIFICATE OF DEATH

Reg. Dist. No.

12952

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) o. STATE <u>District of Columbia</u> COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Germ Dale</u>		c. LENGTH OF STAY IN 1b <u>3 Mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Germ Dale Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Howard</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Sept 1, 1922</u>
9. AGE (In years last birthday) <u>37</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>21</u> Hours <u>21</u> Min.	11. IF UNDER 24 HRS. Months <u>3</u> Days <u>21</u> Hours <u>21</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Messenger</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Internal Revenue</u>	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Howard Williams</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Hampton Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>1-43 to 2-46</u>		16. SOCIAL SECURITY NO. <u>1-43 to 2-46</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, Right, Postoperative</u> 002X DUE TO (b) <u>Pulmonary Tuberculosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>23 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Left Upper Lobectomy 10-5-59; Left Thoracoplasty 11-18-59</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/21</u> , 19 <u>59</u> , to <u>11/21</u> , 19 <u>59</u> that I last saw the deceased alive on <u>11/21</u> , 19 <u>59</u> , and that death occurred at <u>12:10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Glenn Dale</u> M.D.		ADDRESS (Street, city or town, state) <u>GLENN DALE HOSP.</u> DATE SIGNED <u>11/21/59</u>	
PHYSICIAN'S NAME (Type) <u>MOE WEISS, M.D.</u>		<u>GLENN DALE, M.D.</u>	
22a. BURIAL, CREMATION, REMOVA (Specify) <u>11/22/59</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stewart</u> ADDRESS <u>3rd St NE</u>		24a. REC'D BY REGISTRAR <u>DATE NOV 27 '59</u>	24b. REGISTRAR'S SIGNATURE <u>C. L. S. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15091

DETROIT, MI 48201

15092

1

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12938

12859

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>				c. LENGTH OF STAY IN 1b <u>16 Mt. Rainier</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4218-34th Street</u>				d. STREET ADDRESS <u>14218-34th Street</u>			
3. NAME OF DECEASED (Type or print) <u>John H. Wolfe</u>				4. DATE OF DEATH <u>Nov. 9th</u> 19 <u>59</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 20, 1881</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor maker, Ret. Navy Yard, D.C.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Louis Wolfe</u>				14. MOTHER'S MAIDEN NAME <u>Mary Catherine Gaffey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>577-40-5928</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Anterior-calcic Heart Disease with coronary occlusion (Sept 56) and terminal congestive heart failure.</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>and terminal congestive heart failure.</u> (c) <u>failure.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 years +</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 4</u> , 19 <u>56</u> , to <u>Nov. 9</u> , 19 <u>59</u> , that I lost saw the deceased alive on <u>Nov. 9</u> , 19 <u>59</u> , and that death occurred at <u>1 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John F. Finnegan</u>				ADDRESS (Street, city or town, state) <u>1746-K St. N.W. Wash. D.C.</u>			
PHYSICIAN'S NAME (Type) <u>Wash. D.C.</u>				DATE SIGNED <u>4/9/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/12/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home, Inc.</u>				ADDRESS <u>Mt. Rainier, Md</u>		24a. REC'D BY REGISTRAR <u>NOV 12 59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Farris</u>			

1200

ESTABLISHED 1870

1200

The following is a list of the names of the persons who have been admitted to the membership of the Association since the last meeting. The names are given in alphabetical order of their surnames. The names of the persons who have been admitted to the membership of the Association since the last meeting are given in alphabetical order of their surnames. The names of the persons who have been admitted to the membership of the Association since the last meeting are given in alphabetical order of their surnames.

Respectfully,  
The Secretary